NOVEMBER
1943

Medical Economics

THE BUSINESS MAGAZINE OF THE MEDICAL PROFESSION

NOVEMBER 1943

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CIRCULATION 110,000

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25c a copy, $2 a year.

1. There was a lot of trouble and uncertainty in Rip Van Winkle's day, but Rip just slept through it. Some of us might not be averse to doing that these days—if we could.

2. Unfortunately the closest we mortals can come to that is relaxing and getting plenty of regular sleep. Some folks miss even that because the caffein in coffee gets on their nerves.

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Speaking Frankly

Twenty Candles

I want to congratulate MEDICAL ECONOMICS on its twentieth anniversary. The material in it is so presented that one does not have to wade through a lot of unnecessary wordage to get the meat of the subject . . . It is a splendid contribution.

Alton Ochsner, M.D.
New Orleans, La.

Congratulations on your twentieth anniversary!

Russell L. Cecil, M.D.
New York, N.Y.

MEDICAL ECONOMICS contains excellent, helpful, practical material not available to physicians in any other journal . . .

Karl A. Menninger, M.D.
Topeka, Kans.

It is indeed a pleasure to congratulate MEDICAL ECONOMICS on its twenty years of publication. I have followed it from the very first issue, and have always found it stimulating.

Logan Clendening, M.D.
Santa Barbara, Calif.

Congratulations to you on your china anniversary! Among more than twenty physicians to whom I have spoken recently about MEDICAL ECONOMICS, it is the most popular magzine of its type. These men find in your journal the answers to many questions which confront them in practice and for which, in the old days, they could get no answers other than those volunteered by their friends.

Paul A. O'Leary, M.D.
Mayo Clinic
Rochester, Minn.

It is fortunate for organized medicine that between the covers of MEDICAL ECONOMICS it has access to a free and independent expression of thought on present day questions affecting physicians. The magazine has been a consistent leader in shaping professional opinion. Its thought-provoking views and keen analyses challenge the complacent attitudes of many of our men of power.

Happy birthday!

B. T. D. Schwarz, M.D.
Montclair, N.J.

Your publication is broadminded, open to suggestion, and without an axe to grind. Keep it that way!

John J. Nutt, M.D.
New York, N.Y.

I know of no other medical journal that has done as much to put the practice of medicine on a sane financial basis . . .

Fred J. Douglas, M.D.
Utica, N.Y.

. . . MEDICAL ECONOMICS is packed with helpful suggestions and fear-


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less opinions on subjects of vital interest to the profession. It fulfills a need in the doctor's life . . .

Roy B. Henline, M.D.
New York, N.Y.

. . . MEDICAL ECONOMICS is an excellent journal. The editorials by Dr. Baketel are especially helpful and timely . . .

John A. Kolmer, M.D.
Philadelphia, Pa.

. . . I enjoy reading your little publication more than any other I receive . . .

Leo P. Daly, M.D.
Atlanta, Ga.

Homeless

At the conclusion of this war, thousands of competent physicians will have no place to go. They should be given compensation by the state and distributed equitably where they can serve the population best.

R. B. Pryor, M.D.
Pell City, Ala.

Group Practice

In most respects I heartily endorse the conclusions of Dr. Kingsley Roberts in his September article, "Group vs. Solo Practice." However, we must take into consideration the human element. Many doctors do not possess the temperament to work with a group; these men are much better off by themselves.

R. R. Patterson, M.D.
Birmingham, Ala.

Having had eight years as a solo-ist and twenty years as chief surgeon in an industrial hospital, I have come to appreciate the increased efficiency of group practice. Our staff of six most certainly accomplishes as much work as—and, I believe, does that work better than—eight or nine men would do as soloists.

Straight salaries, however, are not the best means of remuneration. A salary, plus a percentage of the take, is preferable.

Hal W. Rice, M.D.
Bisbee, Ariz.

Dr. Roberts' article speaks of the Lahey Clinic and the American Cast Iron Pipe Co. in the same breath. Yet there is vast difference between them. The Lahey Clinic is a private concern. The patient pays for what he gets and gets nothing for which he does not pay. The American Cast Iron Pipe set-up, on the other hand, is run by a company whose employes make almost unlimited demands for service. The doctor must be on tap at all hours of the day and night for colds, headaches, and Sunday-morning hangovers.

I know what I'm talking about. I worked for one of the railroads for a few months. The doctor's main thought under such a system is to get through with his patients and get home as quickly as possible. There is nothing wrong anyway with 90 per cent of the employes who saunter into his office and take up his time.

Allen C. Young, M.D.
Birmingham, Ala.

I have worked in two cities as a member of a group. The problem of dividing the profits was never solved satisfactorily. The group principle, on paper, is ideal, but it will not work unless the members of a group are young men just out of

their hospital service. Doctors who have been in practice for a number of years will not enter a group and stay put.

This is unfortunate since a group of good doctors can do more work, can have more vacation time, and can enjoy more privileges than a solo practitioner enjoys.

M.D., Rhode Island

Group practice offers obvious advantages—especially at this time. Chief difficulties are the tendency to give too little individual attention and the problem of grouping doctors of similar ability and temperament.

Leonard M. Dub, M.D.
Washington, D.C.

Most groups are controlled by one man who holds the pot. To save money for expenses and equipment, he has to pay an enormous income tax. Furthermore, at his death the clinic is subject to a destructive inheritance tax.

If there were some way in which the members of the group could take out their salaries and leave the rest for improvements, and some way in which the equipment and buildings could be turned over to the group without prohibitive taxes, it would be very helpful. I believe certain of the big clinics are classed as educational institutions, which, of course avoids this problem.

M.D., Pennsylvania

My community would be better served if we had a group here. But I am not financially able to organize and operate one. Many physicians with whom I have talked in this state say they, too, would welcome association with a group but

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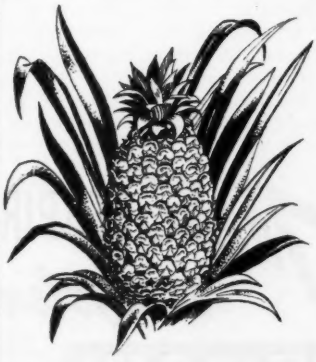

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haven't the means to start one themselves.

You have a good magazine. I appreciate its monthly appearance.

J. Paul Jones, M.D.
Camden, Ala.

In my opinion group practice, when feasible and when not overspecialized, is more practical than solo practice, and will be on the increase after the war.

E. J. Gungle, M.D.
Marana, Ariz.

As a former president of the Niagara County Medical Society and a former president of the medical staff of the Niagara Falls Memorial Hospital, I take this opportunity to elaborate on certain features of Dr. Roberts' recent article.

The future of group practice depends fully as much on its acceptance by the public as on its advantages. Group practice is more popular in the West and Middle West than it is in the East. The cause of this should be determined. If there were a great public demand for groups, we would have more of them.

The average man is accustomed to an individual doctor-patient relationship. It may not be the best thing, but it works. Also, the average man is not as concerned with an ultra-scientific diagnosis as perhaps he should be.

Many groups have been organized. They look good on paper. But most of them have failed.

The public is oversold on surgery; and the surgeons are oversold on themselves. Hence, when it comes to dividing the income of a group, the surgeon demands the lion's share. Surgery is dramatic. Pills are

humdrum. So why shouldn't the featured player in the cast receive his full due, the surgeon reasons.

Surgery has eclipsed all other departments of medicine. As one doctor put it: "Cutting is where the money is." The average doctor is not going to efface himself in the professional obscurity of a group.

The statement that "we cannot lick tomorrow's problems with yesterday's weapons" is clever, yet fallacious. The infantry is one of yesterday's weapons. Yet modern mechanized warfare is helpless without it. Isolated private practitioners are the infantry of modern medicine. The public may not want to pay them; no doubt it prefers that the government pay them with money borrowed from future generations. But it does not want them replaced.

R. H. Sherwood, M.D.
Niagara Falls, N.Y.

I have read with considerable interest Dr. Kingsley Roberts' article, "Group vs. Solo Practice." I have had experience with both types, and I am very much in favor of group practice. Under it, the patient can get better care at lower cost.

S. Fred Strain, M.D.
Wilson Dam, Ala.

I am 100 per cent for solo practice. Group practice makes medical care too costly for the 85 per cent of cases which do not require a specialist's attention.

R. B. McCann, M.D.
Seale, Ala.

I want to cast my vote in favor of solo practice. Doctors are individualists and do not work well in harness. It is a waste of time and material to give every patient the

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1.	**Unnecessary**	Liver extract, vitamins and minerals are frequent ingredients of anti-anemic shotgun mixtures. While each of these has a recognized therapeutic use in its own field, there is no rational basis for combining them in a preparation designed to correct an iron deficiency.
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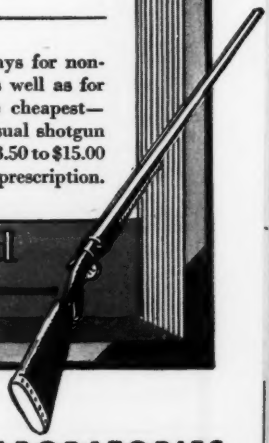
Shotguns are in the red



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microscopic investigation to which he is subjected—theoretically, at least—by a group.

James A. Gannon, M.D.
Washington, D.C.

"Shortage" Rumor

The rumor that the physician shortage precludes adequate care for civilians is a dangerous one. It has been suggested that a doctor be called only in grave illness or emergency. But even a physician is sometimes unable to determine at the first visit whether a condition is serious. How, then, can a layman do it?

There are still enough doctors to give the population adequate care—provided we are called in time. I know of a number of cases where lives could probably have been saved had a doctor been summoned promptly yet where the family, because of the "shortage" rumor, refrained from calling him because they assumed he could not come anyway . . .

James H. Hutton, M.D.
Chairman, Public
Relations Committee
Chicago Medical Society

Birth Control Ban

A correspondent waxes indignant at a ruling of St. Joseph's Hospital, a Catholic institution of Paterson, N.J., which bars physicians who participate in the work of the Planned Parenthood Center of America.

The pros and cons of birth control needn't be discussed here, but it does seem to me that St. Joseph's has a perfect right to conduct itself in accordance with Catholic doctrine, and to bar any one who threatens such doctrine.

It is suggested that the ban be

THOUGHTS FOR THE THINKING REED...

Man is but a reed, the weakest in nature, but he is a thinking reed
—PASCAL

• With the general import of Pascal's great observation there can be no disagreement, but to a more literal interpretation physicians in particular might be inclined to take exception. Men are creatures of strong habits and most of them need others to do their thinking.

Thus, in the matter of nourishment, many people continue to choose what they like or what they are accustomed to, rather than what is necessary for good health.

A report issued by recognized authorities on nutrition points out that "there is a high proportion of poor diets among the employed population," and, as a result, "dietary inadequacies and malnutrition of varying degrees are of frequent occurrence."[1] Deficiencies of the vitamin B complex are considered the most serious of all,[2] and wartime rationing of meat and dairy products can hardly be expected to improve this situation.

Adequate, well-balanced diets are difficult to select, and even more difficult to obtain.[3] This, in addition to the fact that improper eating habits are hard to correct, indicates the administration of vitamin supplements.

* * *

Elixir 'B-G-Phos' is designed for the prophylaxis or treatment of vitamin B complex deficiency, providing *all* the essential B factors and glycerophosphates as well. Supplied in pint and gallon bottles.

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[1] Wolfe, N., McLester, J. S. and Sherman, H. C.: J.A.M.A., 118:944, 1942
[2] Jolliffe, N.: South. Med. J., 34:85, 1942
[3] Boyd, L. J.: Am. J. Dig. Dis., 9:309, 1942

ELIXIR 'B-G-PHOS

tested in court. Shall we also determine whether Catholics may practice Catholicism and whether Methodists may continue to condemn liquor?

J. Edwin Reed, M.D.
Cincinnati, Ohio

Injustice to M.D.'s

Your "Sidelights" department commented recently on an appeal to the Los Angeles County Medical Society by the Lockheed Aircraft Corporation for help in compiling a list of physicians who had regular evening office hours. It seems that Lockheed's employes were in need of medical services for non-occupational ailments, but that the company was not willing to give them time off for treatment. Yet doctors, it appears, should be willing to work overtime to care for these workers.

In any manufacturing plant, when a piece of machinery is ailing, it is taken off production and repaired, whether it's "essential" or not. Doesn't a workman deserve as much consideration as a machine? If he needs medical attention, he should have access to it without penalizing himself or his physician.

M.D., California

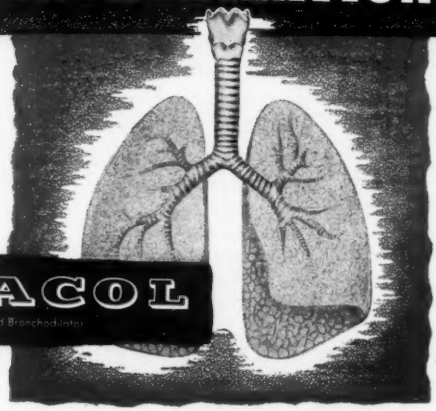
If Lockheed should allow time off for the medical care of non-occupational ailments, so should most other business and industrial concerns. Precedent—if nothing else—militates against it.

Maternity Scheme

As a member of the House of Representatives, from Ohio, I supported the bill which provides maternity care for the wives of enlisted men in the armed forces. It was designed to help the thousands of

More Effective Cough Relief *through* BRONCHODILATION

An ephedrine-like action on the bronchioles, without the undesirable side reactions of ephedrine, is accomplished by the recently synthesized bronchodilator contained in Nethacol.



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women who cannot afford to pay their own medical bills. I should regret it very much if, as has been suggested, the method involved should pave the way for any government control of medicine, for which I have no inclination.

Frances P. Bolton
Washington, D.C.

A major objection to the program is that it provides benefits for those who can afford to pay their own medical bills. For other objections, *see page 51, this issue.*

It remains to be seen how physicians individually will react to the Children's Bureau program. M.D.'s in my town believe that our obstetrical care is worth far more than fees allowed in the federal program. And since doctors must agree to accept no additional compensation, many of us have turned down applicants for this care. Are other doctors throughout the country of the same mind?

M.D., North Carolina

Indexers

Your September article, "Index As You Read!" is a splendid one. It will help me greatly in preserving my references on medical subjects in the years to come.

I can't lose this opportunity to thank you for the many other good thoughts I have gleaned from MEDICAL ECONOMICS.

M.D., Arkansas

Setting up an index system is less of a problem than keeping it going. Every medical student should be required to keep an index of all his medical material, from the beginning of the freshman year through

[*Continued on page* 168]

Sidelights

What's in a name?

Some one should ask the associations that have responded patriotically to the ODT appeal to eliminate conventions and are now holding "wartime conferences" instead.

The increased birth rate has so overwhelmed one Chicago hospital that it has been obliged to tell expectant fathers to keep out—which sounds like a good idea even for normal times. The worried papa-to-be never helps matters by getting underfoot; and often as not he appears on the scene only because he feels obligated to stand by—lest mama and his in-laws think he lacks sufficient parental interest.

Before obstetricians existed as such, childbirth was entirely a feminine affair. A man wasn't supposed to show his face until the midwife's duties were completed. Somewhere along the line, this idea was altered. Now, with a good excuse for telling husbands to stay away, the maternity hospital has a chance to roll back a worthwhile custom.

A good secretary is worth her weight in war bonds. In the medical field, her salary is dependent largely upon the size of her boss's practice, and the present shortage of medical secretaries in some cities may mean that private practitioners can't afford to meet the wage levels which the girls see beckoning all around them. In New York, according to a recent survey, the minimum on which a working woman can exist is $1,480 a year (before deductions). Consequently, top-flight secretaries there aren't likely to be lured by a doctor's want-ad offering less than $30 a week.

Few phrases in our language conjure up a greater depth of meaning than "family doctor." The same could be said of "mother"—until the songwriters discovered it.

HOOK-LINE-AND-SINKER DEPARTMENT (abstracted from the president's page of a county medical society bulletin):

"A goodly number of doctors met to greet Surgeon General Parran of the U. S. Public Health Service. We were all properly indignant that he should have sanctioned the Wagner-Murray-Dingell bill. We were determined to find out what he thought about it. He informed us that he regarded it as the background for some needed changes in caring for the unfortunate sick; and he sold his ideas to the crowd assembled so that 'those who came to scoff remained to pray.'"

Some of the theorists who have written books and articles favoring

compulsory health insurance claim that complete medical care (even including drugs) can be furnished for less than $60 per family per year. The medical profession of California now certifies from actual experience in operating the California Physicians' Service that complete medical care costs at least $100 per family per year. Inasmuch as this new figure is derived from an operating plan which has served from fifteen to twenty thousand families for a period of about a year, it may well influence the financial calculations of subsequently organized prepaid medical care programs, whether tax-supported or voluntary in character.

"Every move the Surgeon General [of the U. S. Public Health Service] would make under the [Wagner-Murray-Dingell] bill would be governed by an advisory board chosen from interested professional groups," says a recent editorial in The New Republic, entitled, "Dirty Work by the Doctors." On the strength of this the magazine denies indignantly that the bill would make the Surgeon General a dictator over American medicine.

Both the premise and the conclusion of the New Republic are incorrect. If Bruce Bliven or Max Lerner or Rexford Tugwell or whoever wrote the editorial had taken the trouble to read the bill beforehand, he would have made two significant discoveries:

(1) the bill permits the Surgeon General to appoint his advisory board himself and (2) it leaves him free to accept or reject the board's recommendations, as he sees fit.

Shades of the Reichstag!

Editorial

How Much Socialization?

Medicine is fast reaching the point where it must declare whether it wants to be tax-supported entirely, partly, or not at all.

Most physicians are hell-bent against *total* government subsidy (state medicine). They favor the principle of *partial* subsidy, however, declaring that the cost of medical care for the poor should fall on society as a whole, not on the private practitioner. They would welcome the actual establishment of such a tax-financed plan for the sick poor were it not for one thing: They're afraid it would gradually be expanded to include everyone, regardless of financial need, thus socializing medicine completely.

Some believe the tendency of the program to hypertrophy could be checked. Others disagree, citing as evidence the inexorable expansion of social security systems generally.

Each day, meanwhile, the need for a united stand on the issue grows more acute. Either we agree to accept tax funds (if offered) for the care of the poor, and take a chance on being able to prevent inclusion in the plan of less needy groups; or we decide against tax support entirely and offer to shoulder the charity load without complaint.

A satisfactory compromise, it has been said, could be reached by ruling out federal aid (and, with it, government domination of medicine) but agreeing to accept local aid (which, presumably, could be controlled to insure the continued independence of the physician). The hitch is that not all states which might be willing to finance the medical care of the poor have the money to do it.

If we conclude that the acceptance of federal or state funds for treating the poor is the less of two evils, we must then decide where we think the line should be drawn in distributing benefits. Should the government subsidize treatment of the totally indigent only; or should it also give some financial aid to the semi-indigent? What limits should be placed on such aid? To what extent should expensive diagnostic procedures be covered? How should "indigent" and "semi-indigent" be defined? These and related questions demand early answers.

—H. SHERIDAN BAKETEL, M.D.

Fellowships Help Rural M.D.'s Take Post-Graduate Courses

One man's philanthropy is aiding many a physician Down East

Well may rural practitioners envy their colleagues in Maine. Physicians in the Pine Tree State have, in recent years, been enabled to participate in a unique program for the advancement of rural medicine—a principal feature of which are fellowships for postgraduate study in Boston.

From simple beginnings back in 1931, the program, known as the Bingham Associates Fund, has been brought to its present stage of development through the philanthropy of William Bingham II of Bethel, Maine.

The fund functions through Boston's New England Medical Center, a group comprising Tufts College Medical School, the Joseph H. Pratt Diagnostic Hospital, the Boston Dispensary, and the Boston Floating Hospital. Cooperating institutions include a number of other hospitals in the Boston area as well as some twenty-four located in Maine.

Aim of the plan is threefold: to provide rural practitioners with (1) comprehensive diagnostic assistance; (2) hospital extension services; and (3) fellowships for postgraduate study, with tuition-free medical courses. To a large extent, these three divisions of the program are interdependent and complementary.

From the outset it was recognized that a program, to be most beneficial to the practitioner, would require more than the usual refresher instruction. A course in electrocardiography, for instance, would be of little help to the rural physician if his local hospital didn't have the proper equipment and if no adequate consultation service were available. The same thing would hold true of instruction in X-ray and laboratory work: Without satisfactory equipment and diagnostic assistance at hand locally, its value would have distinct limitations.

DIAGNOSTIC HELP

One of the first steps was the establishment of a small diagnostic ward (twenty beds) at the Boston Dispensary, to which rural physicians in various parts of New England might refer their more difficult and obscure cases (regardless of the patient's ability to pay). So successful was this experiment that in 1937 the

Joseph H. Pratt Diagnostic Hospital was built—a $700,000 gift of Mr. Bingham.

To this modern, six-story, sixty-five bed institution, New England doctors now refer some 2,500 patients annually, including private, semi-private, and ward cases. No patient is admitted who is not referred by a physician. The latter at all times maintains complete control over the disposal of the case, and his relationship with the patient is not interfered with in any way. Average stay is five days; after it the patient is returned to his own doctor. All recommendations for treatment are made directly to the physician. If surgery is indicated, it is performed only with his full approval.

The Pratt hospital has become the teaching center and heart of the whole Bingham program. That it has been of inestimable help diagnostically to small-town physicians is evidenced by the fact that two-thirds of its patients now come from outside the Boston area.

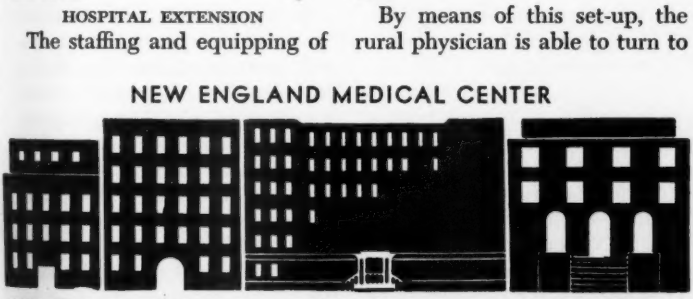
HOSPITAL EXTENSION

The staffing and equipping of regional and local hospitals in Maine has, from the start, been another prime objective in the Bingham plan. Pathologists, roentgenologists, electrocardiographers, technicians, and dietitians have been trained at the New England Medical Center, and a well-worked-out schedule has been devised for rotating these specialists from hospital to hospital.

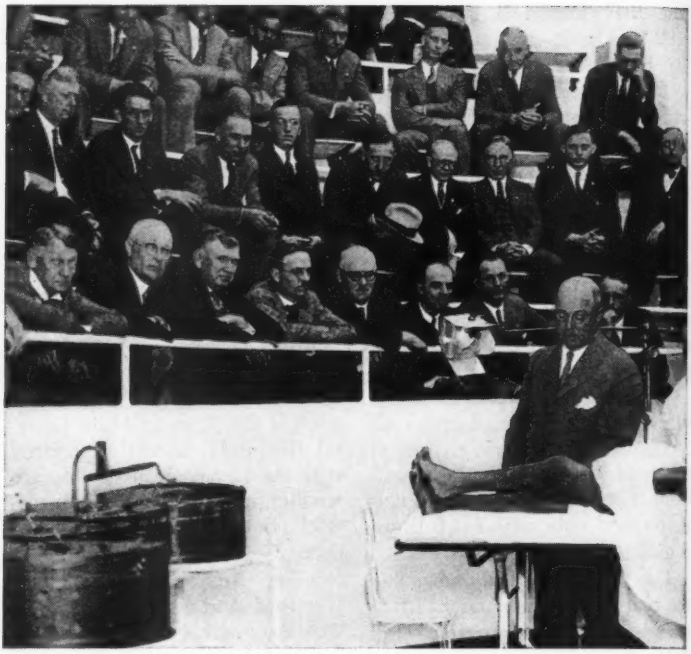
After the state had been zoned, regional centers were established in Lewiston (at the Central Maine General Hospital) and in Bangor (at the Eastern Main General Hospital). Directly affiliated with the Lewiston institution are smaller hospitals located in Brunswick, Bath, Rockland, Damariscotta, Camden, Skowhegan, Waterville, Augusta, Farmington, Rumford, and Boothbay Harbor. The Bangor hospital acts as the regional center for similar small institutions in Greenville, Dover-Foxcroft, Belfast, Blue Hill, Castine, Bar Harbor, Machias, Lubec, Calais, Island Falls, and Houlton.

By means of this set-up, the rural physician is able to turn to

NEW ENGLAND MEDICAL CENTER



Boston Floating Hospital | Boston Dispensary | Pratt Diagnostic Hospital | Tufts College Medical School



The Bingham Fund makes possible a large number of tuition-free courses.

his regional center for technical assistance (if his local hospital lacks a needed facility) and to the New England Medical Center for diagnostic help.

TEACHING WARD ROUNDS

The hospital extension service also includes a special feature designed for the staff members of the Maine institutions affiliated with the program. To these hospitals each month go New England Medical Center instructors to conduct teaching rounds in the wards—an informal type of instruction which brings the center's teaching methods right down to local cases and local conditions.

It is felt that this localized teaching is the best sort of clinical instruction the practicing physician can be given; in effect, it integrates school and hospital, reaching many doctors who are unable to go to Boston for postgraduate study. Its value is enhanced by mail follow-up. Reports and letters, sent from Boston at frequent intervals, keep the Maine men informed of recent developments in fields rep-

resented by their own cases; with the result that their interest in the entire plan remains active and alive. This unique teaching feature has led one observer to remark that it might well be called a "university extension system for medicine."

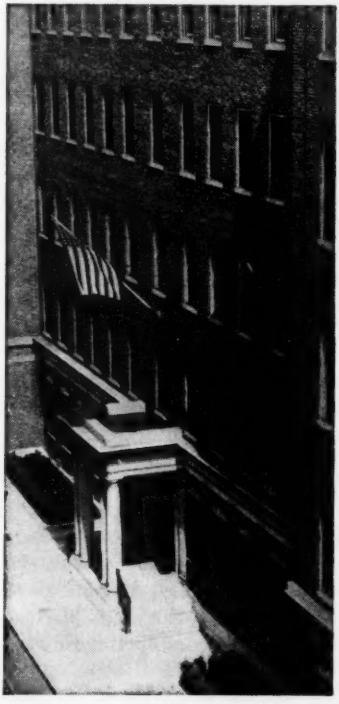
POSTGRADUATE COURSES

The most fascinating phase of the Bingham program, from the individual practitioner's viewpoint, is the opportunity for postgraduate study. Fellowships are available to practicing Maine physicians, and they make it possible for a doctor to spend from a week to a month in Boston taking one or more of the twenty-two courses offered by the postgraduate division of the Tufts College Medical School. (These courses are also open to qualified physicians of other states, but not on Bingham fellowships.)

The administrators of the courses call them "more or less orthodox" and not essentially different from graduate courses given in other medical schools throughout the country. Nevertheless, a number of physicians who have taken them (including several who have studied elsewhere) have, when interviewed, been unusually enthusiastic.

"It's a grand set-up," a small-town doctor told MEDICAL ECONOMICS. "I've been taking postgraduate courses for sixteen or seventeen years and I'd say that the Tufts instruction stacks up with the best. Every year I take one or two courses to brush up, and it's a big help to go there and meet other men who practice in the country districts . . . It gives us courage to carry on." This man had taken graduate work in proctology, cardiology, electrocardiography, and surgery.

Another Maine physician expressed the opinion that the Bingham fund courses are "the best in the country for the general practitioner." He also had



New England doctors annually send 2,500 patients to the Pratt Hospital for diagnoses of obscure ills.

had previous graduate work elsewhere.

Still another, located in a tiny hamlet on the Maine coast, said that he had taken ten of the courses over a period of eight years. He summed up his experience as "one of the most wonderful things that ever happened to me. I won't say I'm making any more money than before," he added, "but I know I'm more interested and understand better what I'm doing. You can't go down there and take a course without becoming more enthusiastic and better fitted to practice afterwards."

A woman physician, recently returned to practice after several years' retirement, called her courses (internal medicine and pediatrics) "a godsend."

It is evident from such comments that doctors who go to Boston for study return to their homes with new enthusiasm and a new viewpoint. Many of them begin referring their problem cases to the Pratt Diagnostic Hospital; some even accompany patients there and follow the detailed work of diagnosis.

SCOPE OF THE COURSES

In duration, the courses vary from four days to four weeks. For the most part, they are given at the New England Medical Center, and combined with ward rounds and clinical observations in various hospitals in or near Boston. Instruction is specially designed for general practitioners.

A brief outline of a few typical courses will serve to illustrate their character and the scope of the subjects covered:

In internal medicine, a four weeks' course is given in October and again in May. Mornings are devoted to ward rounds and staff conferences at the Joseph H. Pratt Diagnostic Hospital and examination of outpatients in the various clinics at the Boston Dispensary, which is just across the street from the Pratt Hospital. Afternoons there are short informal discussions with the chief technicians of the pathology, bacteriology, and chemistry laboratories of NEMC, followed by lectures by the Tufts teaching staff on such specialties as hematology, neurology, gynecology, allergy, cardiology, endocrinology, nephritis, hypertension, and spleen and liver diseases. Enrollment in this course it not limited, but it is usually given (as are most of the postgraduate courses) to small groups ranging in number from four to ten physicians.

In cardiology, a six-day course is available in November and in May. It emphasizes the practical application of present-day knowledge of heart disease, with special attention given to the therapy of heart disorders. Daily lectures cover such subjects as rheumatic heart disease, the heart in pregnancy, hypertension, coronary disease, the less common forms of heart trouble, and the management of cardiac emergencies. These lectures are fol-

lowed by pathological demonstrations and case presentations.

In endocrinology, a five-day course is also available in November and in May. The course includes demonstrations of tests and laboratory methods, attendance at the Boston Dispensary endocrine clinics, lectures, conferences, ward rounds, and examination of patients.

In pediatrics, a four-week course in January includes daily ward rounds at the Boston Floating Hospital and examination of patients there and at the children's clinics of the Boston Dispensary. Afternoons are devoted to visits to the Boston City Hospital, the diabetes clinics at the New England Deaconess Hospital and the Evangeline Booth Hospital (both in Boston), and the Charles V. Chapin Hospital in Providence, R.I., where contagious diseases, diseases of the newborn, prematurity, and diabetes are taken up. Enrollment in this course is limited to four.

Other courses for 1943-44 cover allergy, anesthesiology, dermatology, diabetes, diseases of the bones and joints, electrocardiography, hematology, ophthalmology, otolaryngology, proctology, radiology, and surgery. Courses on cancer and dietetics are given on request when a minimum enrollment of four is possible.

SPECIAL FEATURES

Two features associated with the teaching program deserve special mention. First, living quarters are provided at the Medical Center for those taking the courses. Charges for accommodations are low—$10 weekly for the doctor who shares a double room with a colleague, $12 if has a single room—with low-cost meals available through the purchase of meal tickets. Thus, throughout his stay in Boston, the physician-fellow lives constantly in a medical atmosphere, can mingle freely with resident M.D.'s, with members of the visiting and teaching staffs, and with other post-graduate students from various parts of New England. Everything possible is done to make him feel that he is not an outsider, temporarily there for study, but a permanent integral part of the program. In this way, he is encouraged to go on with his study and to return often for further courses. According to the Bingham plan administrators, this idea has been very much worth while.

Second distinctive feature is a follow-up procedure whereby each practitioner is kept informed by mail of new developments in the field covered by the particular course he has taken. Furthermore, lectures given in the various courses are printed in the bi-monthly Bulletin of the New England Medical Center, which all Bingham fellows receive regularly.

ELIGIBILITY RULES

To be eligible for a Bingham fellowship, a physician must live and practice in Maine, must be a graduate of a recognized med-

ical school, and a member of the Maine Medical Association. In applying for the fellowship, he furnishes the usual information concerning his education, internship, experience, and field of practice, together with references. Also, he must pay a registration fee of $5. Tuition is free, and his travel expenses (including his maintenance in Boston) are covered by the fellowship—which amounts to an allowance of $250 for a four weeks' course, $100 for a course of four or five days. The number of fellowships given to an individual in any one year is at the discretion of the fund's executive committee.

Principal problem encountered by the administrators has been that of making the courses short enough to appeal to the largest possible number of physicians, and, at the same time, long enough to be of real value. The old excuses, "I can't find the time," and "I can't leave my practice," have caused the Bingham committee to shorten many of the courses (originally all were of one month's duration), making the instruction more intensive.

For a time, the fund attempted to send substitute physicians to Maine to take care of the practices of those taking Boston courses; but this idea proved too complicated to be practical.

LOOKING AHEAD

Naturally the war has retarded the development of the program: its postgraduate registration has fallen off nearly a third since 1941 when Bingham fellowships were granted to fifty-one physicians. Moreover, Tufts, like other medical schools, has lost a goodly share of its physician-teachers to the armed forces. Hence, for the duration, the fund plans only to mark time but hopes to resume it gradual expansion after the cessation of hostilities.

To date, some seventy Maine physicians hailing from forty-five different communities, have availed themselves of this chance for postgraduate study. Most of them have returned year after year—proof that the more industrious physicians usually take advantage of the opportunity for self-improvement.

Yearly cost of operating the entire program, including the hospital extension services, is estimated by outside observers to be in the vicinity of $200,000.

Credit for conceiving the original plan is said to belong to Dr. George B. Farnsworth, formerly professor of obstetrics at Western Reserve University and now president of the Bingham Associates Fund. In the development of the program, Dr. Farnsworth had the assistance of Dr. Joseph H. Pratt, clinical professor of medicine at Tufts, the late Dr. J. G. Gehring of Cleveland, and Dr. Samuel H. Proger, also a professor at Tufts and medical director of the Pratt Diagnostic Hospital. Full credit for implementing the program goes, of course, to William Bingham II, whose continued philanthropy

helps advance medicine in Maine.

Whether similar plans will be developed in other localities is, of course, anyone's guess. Investigation in New York revealed that a number of foundations knew little or nothing about the work of the Bingham Fund, that most of them would like to know more about it. Naturally their interest does not imply a readiness to undertake the sponsorship of such a plan; yet long established social-service groups as well as private philanthropists might well consider the recommendations of a county or a state medical society when it has a sound, well-considered plan to put forth, one that will—like the Bingham program—start humbly and develop conservatively. —NELSON ADAMS

P&AS Interne-Resident Policy

Interneships and residencies will be shortened by three months under a 1944 allocation program drawn up by the Procurement and Assignment Service and approved by the Surgeon Generals of the Army and Navy. This will eliminate the three-month overlap of interne and resident services inevitable while hospitals operated on a twelve-month year and medical schools graduated men every nine months.

The new policy is designed particularly to give small hospitals a break. For when institutions offering two-year interneships shifted to a one-year basis, they took about 1,400 internes who, in normal years, would have found staff positions in such small hospitals.

Not only will interneships be reduced to nine months, but one-third of the internes who hold Army or Navy commissions may be deferred for an additional nine months as junior residents. What's more, half these junior residents may be deferred for still another nine months' service as full-fledged residents.

Actually, this formula will not be applied to every hospital. For the fractions indicate simply the overall proportion of commissioned men who will be available for civilian service after January 1, 1944. The armed services are expected to defer but half the residents required by civilian hospitals. The remainder will be drawn from the ranks of

[*Continued on page* 100]

Lessons Found in Failure of Health Insurance Plan

Atypical membership in San Diego upsets actuarial applecart

California Physicians' Service, an organization created by the California Medical Association, has been operating a prepaid medical and hospital service program for more than 15,000 families in a number of housing projects of the Federal Public Housing Authority. On the basis of its experience of about a year and a half—including the spectacular failure of the program in the San Diego area—the CPS is able to draw these conclusions:

1. The contention of proponents of compulsory sickness insurance, that complete medical and hospital care (including drugs) can be furnished for $60 per family per year, is erroneous. CPS experience indicates that the cost is nearer $100 (excluding drugs).

2. General actuarial statistics cannot be used safely in setting up a health insurance program for any restricted group such as war workers in a housing development.

3. Complete enrollment is highly desirable; partial, self-selected participation makes accurate forecasting of costs impossible.

The CPS program for the housing areas was inaugurated in the San Diego district following a request by the county medical society for aid in helping to solve the problem of a physician shortage there. On May 1, 1942, the CPS established a medical center at Linda Vista, where, at a cost of $5 a month, each family of war workers in a housing project was guaranteed availability of doctors and nurses, plus access to participating specialists and hospitalization. Similar service was later established in the Los Angeles area, in Vallejo, and in Marin, Contra Costa, and San Francisco counties.

Today the program continues in all areas but San Diego. There it suspended, in the summer of 1943, amid loud recriminations from subscribers.

Major reasons for the San Diego fiasco, according to the CPS, were: (1) incredible apathy on the part of housing residents; (2) lack of cooperation from the local housing management; and (3) faulty actuarial figures.

Cooperation from the county medical society "was excellent during most of the period in

which this program was operated," says the CPS, "but with an increasing load upon local physicians it became progressively more difficult to secure the continued interest of the local doctors, and this no doubt played its part in the difficulty of maintaining enrollment."

In its first attempts to get subscribers, the CPS found wholesale disinterest on the part of most residents who were not actually ill. The local FPHA management, it says, was suspicious of the service's motives almost to the point of antagonism. "It was only by months of paying through the nose at San Diego," comments the CPS, "that we were able to arouse interest in other housing authorities."

This lack of cooperation plagued the CPS in and around San Diego from start to finish. At no time could the service persuade more than 50 per cent of the housing area's residents to sign up. Yet in other such areas, 95 per cent of the residents have subscribed. The CPS estimates that 90 per cent enrollment of those eligible is essential to the proper working of its program.

Wherever it functions, the CPS offers identical benefits. These include complete medical, surgical, and hospital care. The cost to families has been $5 a month, but an increase in rates was recently decided on. Premiums are collected by the housing authorities, along with rent.

Collections from all housing areas are pooled in a state fund and disbursed by the CPS. The service enjoys full authority (free of government control) to shape the professional aspects of its program in any way it sees fit. Physicians are paid a pro rata share based on the amount of work they have performed. Subscribers enjoy free choice of participating physicians—one survey indicated that 85 per cent of all California doctors were participating.

In its early days at San Diego the CPS had to recruit its own subscribers. Then when the Federal Public Housing Authority*—impressed by the high quality of medical service being furnished in the San Diego district—invited the CPS to install a similar service in other areas, it agreed to take over the job of recruiting subscribers. CPS was so encouraged by this turn of events that it liberalized its benefits on the theory that participation would increase considerably. But San Diego remained apathetic even when residents of the other housing areas participated almost 100 per cent.

In May 1943 the CPS warned the San Diego FPHA office that unless participation increased, the program would have to be abandoned. Participation did not increase; so, amid loud protests from civic groups and the local press, the plan was forced to fold up on August 1. [*Turn the page*]

*National headquarters—not the unfriendly local FPHA office.

Why did this program, blessed by organized medicine and admittedly doing a top-notch job, go on the rocks?

From the beginning, says Dr. A. E. Larsen, CPS executive medical director, FPHA officials at San Diego extended virtually no cooperation—in fact they actually hindered the plan's progress. (Officials at other projects have supported CPS plans wholeheartedly.) Secondly, says Dr. Larsen, since enrollment at San Diego was meager, it naturally included a disproportionate number of persons who needed immediate medical attention. Furnishing them with extensive care endangered the CPS not only in San Diego but all over the state, because of the pooling arrangement. "Professional members and housing authorities in other localities were in almost open revolt against the continuation of such an unbalanced program," the director says. For every dollar taken in, the CPS returned $1.70 in medical and hospital service to San Diego subscribers.

Another significant factor was the failure of the obstetrical program to work out according to forecasts. These forecasts were based on the birth rate of the first three months of 1943: 22 per 1,000. But to be on the safe side, CPS calculated rates on an expectation of 27 to 30 per 1,000. Actually the birth rate in the housing projects turned out to be about 100 per 1,000.

The CPS can't fully explain this phenomenon, but it has found a few clues: For one thing an abnormally high percentage of war workers are of the child-bearing ages; the percentage is much greater than would be found in a true cross-section of the general population. Then, too, most of them now enjoy a much higher income than they had during the past decade, and they feel they can at last afford to bring up a family.

The CPS hung on as long as it could in the San Diego area, but wholesale resignation of doctors (discouraged by the heavy burden of work and the small financial return), coupled with excessive demands for service by subscribers, finally tolled the bell. Local newspapers promptly charged that doctors were running out on their patients, and the local FPHA office seized on the occasion to wash its hands of the CPS entirely, hinting, at the same time, that the program might not have failed if the government had had a greater say in the management of the plan. The Linda Vista Civic Committee invited subscribers to come to it with their woes, and it ultimately hired a lawyer to see what could be done about forcing the continuation of medical treatment in progress when the plan broke up. Many a subscriber who had joined in expectation of obstetrical service was especially irate.

At this writing, the San Diego area is still without CPS service.

—CARLSTON CHAMBERS

Federal Maternity Program Arouses Further Protests

Benefits modified for service men's wives, but opposition continues

More and more physicians are bitterly criticizing the government's program to subsidize maternity and infant care for wives and children of enlisted men. The shock that galvanized many of them into action came late in September when Congress voted another $18,600,000 for the Children's Bureau of the Department of Labor to distribute to participating states, making a total budget, so far, of $24,200,000. Until then the bureau had been struggling along on $5,600,000, representing two previous appropriations.

After the last bonanza, resolutions from medical societies and statements from their leaders came in such a rush that two concessions to critical public opinion were almost overlooked. One was the decision of Congress to require certificates of financial need from wives whose husbands were in the top three grades of enlisted men (those above the rank of line sergeant). The other, announced two weeks later, was the decision to exclude such beneficiaries altogether. Under the original plan dependents of enlisted men in all seven grades were eligible for benefits whether in need of assistance or not.

Meanwhile, present restrictions by no means remove the profession's fundamental objections to the program. Osteopaths, chiropractors, midwives, and cultists still are eligible to practice obstetrics under the program in many states. Fees still are paid directly to doctors by state health departments. There is the same limitation on free choice of doctor and hospital. And it is felt that the threat of future government interference with medicine—the opening wedge having been inserted—still exists. Consequent-

¶The government-sponsored Children's Bureau program to finance obstetrical and pediatric care for wives and children of enlisted service men is coming in for an increasing amount of criticism. In September, MEDICAL ECONOMICS described how the plan works; last month, an article reported on serious opposition to it throughout the nation. This present account focuses a flood of criticism provoked by a third Congressional appropriation, which brings the total sum provided so far to $24,200,000.

ly, still more medical associations have now joined the fight.

The Michigan State Medical Society, for example, recently suggested that its members provide free maternity service for wives of enlisted men until the Children's Bureau changed its methods, pointing out that direct payment to the doctor by the health department threatens to destroy the physician-patient relationship. It branded the program a clear-cut case of government subsidy of the profession—or state medicine. On this point, Dr. L. Fernald Foster, the society's secretary, remarked:

"Wives of service men, not doctors, should be subsidized . . . We are 100 per cent in favor of soldiers' wives getting all the help they can, even to the extent of footing the bills ourselves if necessary. We would rather do this than be subsidized."

Dr. Edwin F. Daily of the Children's Bureau countered with the claim that funds might not be properly used if the government gave cash benefits direct to mothers. He also asserted that such an arrangement would result in twice as many applications for maternity aid, since the present plan provides for only ward accommodation. Pointing out that more than 3,500 wives in Michigan have already received benefits, Dr. Daly made it clear that the bureau intends to continue its plan there no matter what doctors think about it.

The Indiana State Medical Association reluctantly accepted the scheme after its executive committee decided that the profession couldn't afford to be "put on the spot" by opposing it:

"The executive committee . . . is sure that the action taken . . . with regard to maternity and pediatric care of *needy* wives and children of enlisted men will meet with the hearty cooperation of the medical profession of Indiana."

This policy was amplified by the society's journal:

"The committee . . . is strongly opposed to the expenditure of federal and state moneys to pay for medical services rendered to any family of any individual, whether the head of the family is a civilian or a member of the armed forces, when he can afford to pay for medical attention which involves maternity and pediatric care."

Forthright opposition has been voiced by the Albany (N.Y.) County Medical Society, which charges that the program establishes a "direct government-physician relationship which we sincerely believe to be detrimental to the well-being of wives and infants of service men and ultimately to the interests of the nation as a whole."

Dr. Joseph O'C. Kiernan, chairman of the society's maternal welfare committee, added that in some respects the plan violates the constitutional rights of wives, and that in others it is an "affront" to the profession. Dr. Kier-

nan lambasted the New York State Health Department ruling that doctors must sign a statement agreeing to abide by its rules both as they now stand and as they may be "subsequently amended."

"If we physicians have reached the place where we have to have rules from the state health department, something is wrong," Dr. Kiernan commented. "I certainly would not sign a statement to abide by a rule 'as subsequently amended.'"

At least one professional organization has taken the Ohio State Medical Association to task for abandoning its early fight against the government program (MEDICAL ECONOMICS, October). The Ohio society quit in the face of a series of what it called "political" attacks by newspapers, legislators, and others, although it reiterated its belief that the Children's Bureau program was wrong "in principle." Following this move, the Columbus (Ohio) Academy of Medicine said:

"The... association should have stuck to its guns... Nothing is gained in dealing with a wily and unscrupulous enemy by sounding off about principles... Wives of service men would welcome a little boost to their rather meager allowances from the government, but certainly don't want to be pauperized in any such unwarranted and high-handed manner.

"Obviously, free choice simply does not exist under any such setup... It was not the welfare of the mothers but the opportunity to regiment the medical profession that motivated the New Deal in this contemptible scheme.

"How else can they justify their refusal to pay the money direct to the mother, or their refusal to separate the hospitalization and the medical service? If the doctor is unwilling to accept any such arrangement, the mother is denied hospitalization benefits.

"The plan also plainly stipulates that hospitals are to provide only ward care, for which they are paid ward rates or better, whereas the doctor is obviously in no position to cut the cloak to fit the cloth. Each doctor could do nothing less than render the best service of which he is capable, whether these services are worth forty dollars or a hundred... If the patient were really allowed free choice she would not be limited to the doctors who would snap at the chance to deliver a baby for thirty dollars."

The Jackson County (Mo.) Medical Society labels the scheme a "pennies-from-heaven" inspiration, and comments caustically on the fact that Congress has already had to appropriate money on three different occasions ($1,200,000; $4,400,000; and $18,600,000) to sustain the program.

"Undoubtedly the commendable concept was to emulate the parable in which the multitude was fed on the loaves, but it has turned out to be more like feeding peanuts in the zoo," the so-

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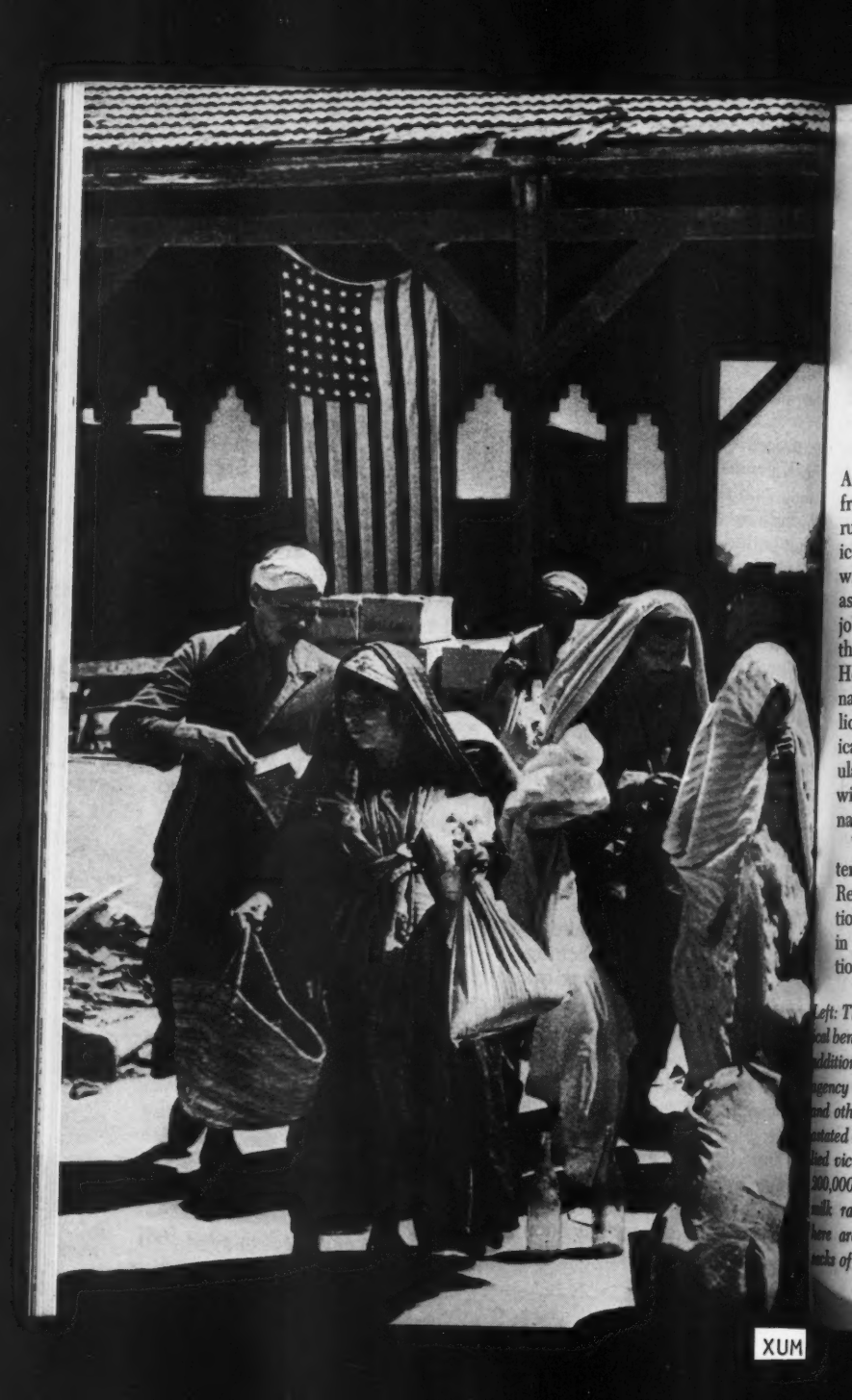

U.S. Sending Medical Teams To Liberated Countries

Administrators will help native doctors re-establish services

As the Allies drive Axis armies from the countries they've overrun, small teams of American medical men and sanitary engineers will enter the reconquered areas as medical administrators. The job of the physicians—many of them recruited from the Public Health Service—will be to help native doctors, hospitals, and public health authorities restore medical services for the stricken populations. Only in emergencies will the American physicians treat natives directly.

The program is being administered by the Office of Foreign Relief and Rehabilitation Operations, an agency whose exact niche in the government's organizational pattern has not at this writing been decided. Until recently under the jurisdiction of the State Department, the OFRRO is now part of the newly created Office of Foreign Economic Administration, and by the time this article appears it probably will have been absorbed by the United Nations Relief and Rehabilitation Administration. It appears reasonably certain, however, that the organization, whether as an American agency or as a unit of the international body, will carry on its assigned task.

Chief medical officer of the OFRRO is Dr. James A. Crabtree. He is a Public Health Service man and was formerly medical consultant for the Lend-Lease Administration and deputy medical director of the Tennessee Valley Authority.

Created about a year ago, the OFFRO went through a period of research and planning before putting its program together. It had the assistance of an advisory board, consisting of representatives of various governmental and private agencies. Chairman of the committee was Dr. Thomas Parran, U.S. Public Health Serv-

Left: These Tunisian Arabs are typical beneficiaries of OFRRO work. In addition to its medical program, the agency ships food, clothing, fuel, and other essentials into areas devastated by war. Shortly after the Allied victory in North Africa, about 200,000 children were given daily milk rations. The women shown here are preparing to take home sacks of food provided by OFRRO.

ice. Members included Col. James S. Simmons, U.S.A.; Commandr. T. J. Carter, U.S.N.; Dr. Martha Eliot, Children's Bureau; Dr. Alfred Cohn, BEW; C.-E. A. Winslow, Yale University School of Medicine; Dr. Frank G. Boudreau, director, Milbank Memorial Fund; and Selskar Gunn, vice president, Rockefeller Foundation.

The medical rehabilitation plans were translated into action with the American invasion of Africa. Just as soon as our troops had taken a foothold there, the OFRRO dispatched three men, borrowed from the Public Health Service, to help re-establish civilian medical services for the native inhabitants. A few months later two more doctors joined them. Working directly under General Eisenhower, these men had access to American Army supplies when no local material could be found, but otherwise they stuck to the plan of using North African physicians, hospitals, nurses, and medical supplies wherever possible. Among the accomplishments of this first team sent abroad has been the organization of a public health department in Oran.

As the Allies push forward in their European invasion, they will be followed by OFRRO personnel. New teams are being organized. They will be highly trained and completely equipped, for—since relatively few men will be sent abroad—it is essential that they be prepared to handle all the problems likely to be found in territories the Allied forces reconquer.

Each team will be headed by a principal medical officer, probably drawn from the PHS. The No. 2 man will be a sanitary engineer. Other team members will include a pediatrician, a medical supply officer, a nutritionist, and a public health nurse. When it's considered necessary, the teams will be augmented by a hospital administrator, a malariologist, an entomologist, a tuberculosis man, and a specialist in tropical diseases.

The OFRRO is also accumulating supplies in this country to be shipped abroad as they are needed. Later on, supply depots may be set up at strategic points in Europe and Africa. Several different forms of "package" equipment are now being assembled here.

For example, there is a so-called "basic emergency unit" consisting of some 150 items which are regarded as an "irreducible minimum for basic medical needs." This unit is designed to fill the medical requirements of 100,000 people for one month. Multiples of it are ready for shipment to any area of need as a follow-up of the initial stages of military operations.

Then there is a "standard unit," which consists of approximately 1,500 items, ranging from ordinary remedies for colds and headaches to equipment for water-

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This Engineered Office Cuts Demands for Home Calls

Unique layout saves doctor's time and gives patients complete privacy

Ripleyan though it sounds, a New Jersey pediatrician has reduced his volume of house calls and proportionately increased office calls by redesigning his office. He has also achieved at least two other highly gratifying advantages: (1) He can now do his work with less waste motion, and therefore handle office visits in considerably less time than before. (2) Mothers who must await their turn to see him now do so more cheerfully, because of the privacy they enjoy.

Dr. W. R. Little of Trenton is the man. His hobby is home and office engineering. When he remodeled his professional quarters he designed three four-purpose rooms; each serves as a complete consultation, examination, treatment, and reception unit. A prime object in doing this was to avoid having more than one patient at a time in the regular reception room. This, of course, is a concession to mothers who, for fear of contagion, are reluctant to have their children wait in a room full of other children. It also appeals to those who don't relish trying to make their children behave in public, or who simply dislike the atmosphere of a crowded reception room.

Before he remodeled, Dr. Little found that mothers often tried to make appointments at odd hours, on the theory that other patients would not be at the office then. Some insisted on home calls, even for minor ailments. These annoyances are now a thing of the past. Here is how the present arrangement works:

Facing a corridor which runs toward the back of the building from the regular reception hall (see floor plan) are three rooms approximately equal in size (about 8′ x 11′) and furnished identically. Each is equipped with an examination table, baby scales, a metal treatment cabinet, desk, washbasin, chairs and a small settee.

The first mother who arrives is immediately assigned to Room 1; the next is taken to Room 2; and the third to Room 3. Under ordinary circumstances (patients are seen by appointment only) all callers can be accommodated in these three rooms. But if more should arrive, the laboratory, reg-

Each room is completely equipped for both consultation and treatment.

ular consultation room, and, of course, the regular reception room can be used.

A secretary-nurse does a good deal of the preliminary work. After she assigns the patient to one of the rooms, she writes a routine history, weighs the child, takes its temperature, and takes whatever other preliminary steps are in order. She may also instruct the mother to undress the child before the doctor comes in.

Having placed the case history in the desk drawer, the nurse indicates on a chart in the hall, the name of the patient, the time of the appointment, the room number, and, whenever possible, the nature of the treatment. By consulting this, Dr. Little knows which room to visit first. He also knows, in many cases, what treatment is indicated. Thus, if the child is there for an inoculation, the doctor can prepare the syringe and bring it with him when he sees the patient for the first time. (A sterilizer is located in the hall so that inoculations may be prepared without the child seeing what is being done. Except for this, each of the three rooms is completely equipped.)

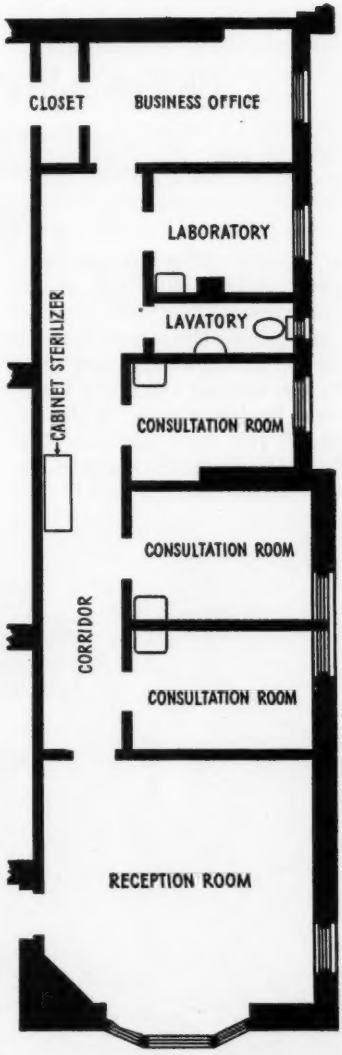
A marked advantage of this office is that no mother feels she is being rushed. At the same time, something is nearly always going on to keep her and her child occupied. Thus, while she is waiting for the doctor she is busy undressing her baby or giving preliminary information to the nurse. Then, too, she is in a private room where she can talk to friends or relatives who may have come

along to drive the car and keep her company while she tends the baby.

Before he remodeled his office, Dr. Little found that mothers commonly wanted what amounted to two consultations: One before the examination and treatment and one afterwards. This meant a trip from the consultation room to the treatment room, and then back to the consultation room again. Now, with everything done in a single room, this waste of time and energy is eliminated.

When he has finished with a patient, the doctor presses a button which flashes a light in the hall, indicating to the nurse that the room can then be prepared for the next consultation. However, no mother is hurried. There are times, obviously, when an appointment conflicts with a baby's feeding hour. In such a case the mother is free to give the baby its bottle in the office. Since the doctor can work in the other rooms, this does not interrupt his schedule. Nor does the time-consuming chore of undressing and dressing the baby slow him up. This means, of course, that the next patient does not have to wait for him so long.

Dr. Little starts at Room 1 and works down the hall. By the time he has finished with the patient in Room 3, the first room has been cleared and another patient is ready for him. Each room, incidentally, has been soundproofed —an evident advantage to a pediatrician. —WILLIAM R. BRUCE

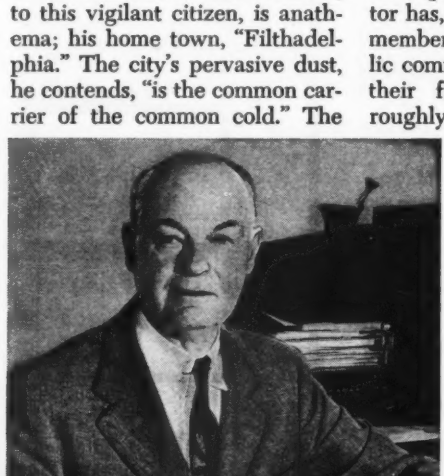


With this new lay-out, there need never be more than one patient at a time in the reception room.

Philadelphia's Dust-Buster

For forty years he has campaigned against "pulverized poison"

If, while strolling through downtown Philadelphia, you should come upon a man sniffing the air suspiciously, chances are it would be Dr. Howard S. Anders. Dust, to this vigilant citizen, is anathema; his home town, "Filthadelphia." The city's pervasive dust, he contends, "is the common carrier of the common cold." The smoke of Pittsburgh, on the other hand, he dismisses as merely irritating and nauseous. In his one-man campaign against what he calls "pulverized poison," the doctor has, for as long as he can remember, been issuing angry public communiques on the subject, their frequency corresponding roughly to increases in the amount of dust he detects in the Philadelphia air. He thinks the city is cleaner today than it used to be, but he recalls many a time when he felt justified in comparing it unfavorably with the Dust Bowl. Seventy-seven years old this month, Dr. Anders admits he is slowing up a bit. From his modest downtown office, he looks back a little wistfully over his fifty-three years of general practice and two-fisted public agitation. He has long been tolerant—even proud—of the fact that he is known as a "crank" about dust. In forty



years he has made countless speeches before civic, religious, and medical groups, written hundreds of letters to newspaper editors, and buttonholed many a legislator. Right now he is writing a book for laymen which he tentatively calls "Deliver Us From Dust."

All seasonal colds (he prefers to call them "fouls"), as well as many eye, nose, throat, and lung disorders, may be blamed on dust, he contends. Furthermore he believes that about 70 per cent of heart ailments are, in the last analysis, the result of dust infection. He once told the Society of Mechanical Engineers: "If you fellows could devise some means of reducing dust in the air by 50 per cent you'd prevent more disease than all the doctors put together."

His dust theory is neatly summed up in this letter which he sent to a Philadelphia newspaper:

"Dust in houses, apartments, hotels, cars, movie theatres, department stores, shops, telephone booths, places of industry, churches, wherever people congregate to mingle and erupt their sprays of sneezing, coughing, and spitting—such dust catches the myriads of specific disease-producing microbes, and like the motes we see in sunlit beams, moving airplanelike, carries the ultramicroscopic molecules or virus particles for implantation into the unsuspecting, with their soft, warm, moist, culture-medium crevices, folds, and follicles of the respiratory linings."

The peculiar cadence of his prose style, evident here, reaches even fuller bloom in some of his correspondence. In speaking of a forthcoming book he once wrote: "I have in process of publication a book, historical and rational, clinical, bacteriological, sanitary, and practical . . . It's really a fascinating and forceful, serious and sensible problem."

Dr. Anders' fascination with dust dates back to his senior year at the University of Pennsylvania Medical School, when a study he made convinced him that the incidence of disease is higher among people living on narrow streets than among those on wide streets. Soon after that he began campaigning for clean streets—wide or narrow. He still recalls with relish the time, around the turn of the century, when he persuaded the Philadelphia street-car company to stop outfitting its trolleys with plush seats. "They were a beautiful crimson color, and they were just dandy dust gatherers," he says.

Although Dr. Anders has always maintained a high level of indignation at dust, he has missed few opportunities to stir up controversies on other aspects of sanitation. For instance, in the first paper read before his county medical society he recommended that churches be urged to adopt individual communion cups. This threw Philadelphia into an uproar; a local bishop announced

that Dr. Anders was unquestionably an infidel. But ten years later the doctor made a survey which indicated that 25,000 churches had followed his suggestion.

In 1897, he began an anti-spitting campaign which culminated in a state law making spitting in public places a misdemeanor. Although the law isn't enforced very often, he thinks that anti-spitting signs on streets and in railroad stations have gone a long way toward educating the public. A decline in tobacco chewing has helped, too, he admits.

During the Gay Nineties he began to agitate for the creation of a state hospital for the not-so-gay consumptive poor. He collared legislators during the sessions of '99, '01, '03, and '05, and finally harangued them into appropriating $15,000 for the project. That was the beginning (at a time when only one other state had such an institution) of the large sanitarium at Mont Alto, which today can care for 2,000 patients. In gratitude, the Pennsylvania Society for the Prevention of Tuberculosis promptly elected him its president.

Dr. Anders is especially proud of a study he once made of the relationship between weather changes and influenza epidemics. For this achievement he was elected a fellow of the Royal Meterological Society of London, a distinction he thinks he shares with no other American physician. He also points with pride to a fight he had against the indiscriminate use of whisky in hospitals. "When I was an interne," he says, "the chief, as a matter of routine, would order whisky punches every three hours for all patients suffering from pneumonia or typhoid fever. Boy, did they like it! And, boy, did they get worse."

In 1932 he advocated periodic health examinations, especially for the unemployed, at state expense. Doctors were to be paid a nominal fee, perhaps $2, by the state treasury. He still thinks highly of this proposal.

Dr. Anders estimates the value of his services to the public at somewhere in the neighborhood of half a million dollars, but says this is probably a conservative figure. His talent for versatility, he feels is in the tradition of Jefferson, Gladstone, and Theodore Roosevelt. He also pays tribute to his one-time professor of astronomy who wrote in the Anders autograph book: "Ride more than one hobby." This principle has become fundamental to the doctor's creed. "One of the hobbies I've ridden is that of studying trees," he says. "Why, I often pat the trunk of a tree like I'd pat the back of a fellow human."

Dr. Anders is convinced that background is significant in the development of character. "From the purely biological standpoint we are not responsible for ourselves," he points out reasonably. On this score, though, he thinks he is singularly fortunate, because his ancestors who came to

Philadelphia from Silesia 209 years ago, were all followers of the religious reformer Kaspar Schwenkfeld, "a man of uncommon religious and intellectual virtuosity." Dr. Anders insists, by the way, that he comes from Pennsylvania-German stock, not Pennsylvania-Dutch, a term he considers inaccurate.

Every September his clan holds a reunion to commemorate the ancestral landing in America. Ordinarily, Dr. Anders drops in on the party; but this year he was too busy to get away, a fact he deeply regretted. He finds that just being with his kinfolk stimulates him to engage in bigger and better crusades. "My whole family is full of talent," he muses.

—GEORGE BARRETT

The Halogen Kids

The colored midwife who officiated at Utility Skimpey's initiation into the universal sorority was obviously disappointed when she discovered the fruit of her labor was a girl-baby. But the cloud remained for only an instant—a happy thought brushed it aside:

"I know a sweet name you can call her!" she beamed—"Florine. Now ain't that a pretty name?"

"Sure is!" Utility agreed, and the name was duly inscribed upon the bright blue birth certificate.

A year later, when Utility had once more attained the fullness of her time, I was summoned to serve as accoucheur. I brought her no better luck than my predecessor. I delivered a little sister for Florine.

"What we goin' to name this child, Doctor?" my patient asked wistfully.

"I don't know. I just can't think of a good name, at the moment."

"What makes a rhyme with Florine?"

"Chlorine," I answered absent-mindedly.

"Chlorine! You sure can think of pretty names. Yes, sir! That's exactly what we'll name her—Chlorine. Write it down there before you forget it."

When Utility sent for me the next year, I drove toward her home cheered by the thought that the law of averages was on our side. I

[*Continued on page* 117]

Forms That Help You Figure The Pay-As-You-Go Tax

1944 quarterly payments will be based on income estimates

The new pay-as-you-go income tax isn't as complicated as it looks though it does impose some additional accounting responsibilities on the man who derives all or part of his income from private practice. Even with that, the average physician should be able to compute his tax without trouble. The chief problem is to arrive at a reasonably accurate estimate of taxable income. Treasury interpretation or future legislation may result in modifications here and there, but it is likely that in broad outline the law will remain unchanged in the immediate future.

Under the act, physicians are required to make four quarterly tax payments next year on their 1944 incomes. Each payment must be computed on the basis of the doctor's *estimate* of what his income tax and Victory tax will be, which, in turn, he computes from an *estimate* of income for the entire year.

These estimates may have to be revised upward or downward each quarter, depending, of course, upon the accuracy of his forecast. Therefore each quarterly payment, after the first, must reflect changes in the income estimate. The reason for this is the government requirement that the tax installments paid for the four quarters must total at least 80 per cent of the *actual* tax due for the year. (This final computation, made after Dec. 31, will, obviously, be based upon actual income for the twelve months.)

To illustrate: Take the case of Dr. Sylvester, a general practitioner with moderate investments and a monthly retainer of $100 from an industrial practice. We'll disregard the "forgiveness" complication, which applies only in exceptional cases, and which will be provided for in forms supplied by the government. Let us, then, consider a routine method for Dr. Sylvester to keep a record of taxable income.

He uses a bookkeeping system which enables him to keep track of monthly income and expenses and arrive at *net* income figures month by month. With that, and two forms like those illustrated here, he will not find it difficult to estimate his 1944 income and compute his quarterly

tax estimates and payments.

When the time grows near for his first tax payment in 1944, Dr. Sylvester turns to his "Comparative Income Schedule." Using his 1943 records, he fills in column 1 with actual *net* 1943 figures covering professional and other income. He then estimates, month by month, what he will earn during 1944, entering these figures in column 2. (He may wish to do this in pencil so the figures can be altered as the year goes on.) Later, the actual 1944 figures will be entered in column 3.

Dr. Sylvester now turns to the form provided quarterly by the Bureau of Internal Revenue to estimate his total tax. If his income after deductions for family status is less than $10,000, he uses the table printed on the government form, which shows at a glance the average tax due by income groups. If his taxable income is more than $10,000 (or if he prefers to compute his exact tax regardless of the amount of his earnings) he may obtain a working sheet from his revenue office.

Let us assume that Dr. Sylvester estimates his taxable income at $8,800 for 1944. He is married and has two children, which entitles him to a total deduction for dependents of $2,120. Subtracting, he gets the taxable amount, $6,680. Then, referring to the government table, he finds that on amounts between $6,600 and $6,800, the estimated tax is listed as $1,371.

He then computes his Victory tax by taking 3 per cent of $8,800 (less $624 exemption). This amounts to $245.28. By adding this to $1,371, he finds that his total estimated 1944 tax liability is $1,616.28.

Dr. Sylvester then turns to the sheet headed "Quarterly Income and Victory Tax Payments." He enters the $8,800 figure on line 1, and the $1,616.28 figure on line 2. Since he has claimed no exemption upon his industrial-practice salary of $100 a month, the full $20 (20 per cent) is deducted at the source each month. He therefore is entitled to deduct $240 for the year (since he figures the full $100 salary as part of income, and tax has been paid on it), so he enters that figure on line 3.

Now by substracting, he learns that his net estimated tax is $1,376.28, a figure which he writes on line 4. One-fourth of this—$344.07—must be paid by March 15, 1944. The doctor then transfers the data he has collected here to the form he will file with the Collector of Internal Revenue (along with his final report for 1943 and the unforgiven portion of his 1942 or 1943 taxes). So much for the first quarter.

By June 15 Dr. Sylvester discovers that he is doing better than he had anticipated. He decides that his income will now be close to $9,500. And so, repeating the process described, to get new income and tax estimates for the year, he arrives at a new tax

COMPARATIVE INCOME SCHEDULE

	1943 ACTUAL		1944 ESTIMATE		1944 ACTUAL	
FIRST QUARTER						
Net Income from Practice						
January	713 69		750 00			
February	595 34		600 00			
March	667 80		700 00			
Total Quarterly Professional Income	1956 83		1950 00			
Add Income from All Other Sources	240 07		250 00			
Total Net Income for Quarter		2196 90		2300 00		
SECOND QUARTER						
Net Income from Practice						
April	515 70		575 00			
May	646 33		675 00			
June	661 15		675 00			
Total Quarterly Professional Income	1823 68		1925 00			
Add Income from All Other Sources	113 00		125 00			
Total Net Income for Quarter		1936 68		2050 00		
THIRD QUARTER						
Net Income from Practice						
July	486 01		500 00			
August	515 62		600 00			
September	742 28		750 00			
Total Quarterly Professional Income	1743 93		1850 00			
Add Income from All Other Sources	113 00		150 00			
Total Net Income for Quarter		1856 93		2000 00		
FOURTH QUARTER						
Net Income from Practice						
October	620 87		700 00			
November	734 60		750 00			
December	643 43		700 00			
Total Quarterly Professional Income	1998 90		2150 00			
Add Income from All Other Sources	213 39		300 00			
Total Net Income for Quarter		2211 07		2450 00		
TOTAL NET INCOME FOR THE YEAR		8717 83		8800 00		

SUGGESTIONS

Net income from practice may be posted from Monthly Balances in your 1943 DAILY LOG, or reconstructed from other sources. The 1944 estimate should be based upon the current trend, and may be penciled so that figures can be altered if advisable.

Income from all other sources will include dividends, interest, rents and net profits from farming and any other business. Original figures should be found on the Personal Account Sheets in the LOG.

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total of $1,803.28. Thus, his second quarterly estimate will show $9,500 on line 1, and $1,803.28 on line 2.

He then deducts the $240 withheld from his industrial-practice salary, and finds that his first payment of $344.07, deducted from the new estimate, leaves a balance now due of $1,219.21 unpaid. His second installment is therefore $406.40, or one-third of the balance due.

If necessary, he will repeat the

process in September and December, when his third and fourth installments fall due. After Dec. 31, using exact figures of income and expense, he can compute his exact tax. At that time, let us say, he finds that he still owes $18.08. That is well within the 80 per cent figure specified by the Treasury Department and therefore he is subject to no penalty.

—JAMES L. KELLY

QUARTERLY INCOME AND VICTORY TAX PAYMENTS

FIRST QUARTER		
1. Total Estimated 1944 Net Income (from Comparative Income Schedule)		$ 8800 00
2. Estimated Income and Victory Tax for 1944		$ 1616 98
3. LESS Estimated Income and Victory Tax Withheld During Entire Year 1944 (If any)		$ 240 00
4. BALANCE OF UNPAID TAX (Item 2 Less Item 3)		$ 1376 98
5. TAX PAID MARCH 15 (Not Less Than ¼ Item 4)		$ 344 07
SECOND QUARTER		
1. Total Estimated 1944 Net Income (from Comparative Income Schedule)		$ 9600 00
2. Estimated Income and Victory Tax for 1944		$ 1803 78
3. LESS (A) Est. Income and Victory Tax Withheld During Entire Year 1944	$ 240 00	
(B) Tax Paid March 15	$ 344 07	$ 584 07
4. BALANCE OF UNPAID TAX (Item 2 Less Item 3)		$ 1719 71
5. TAX PAID JUNE 15 (Not Less Than ½ Item 4)		$ 406 40
THIRD QUARTER		
1. Total Estimated 1944 Net Income (from Comparative Income Schedule)		$ 9600 00
2. Estimated Income and Victory Tax for 1944		$ 1803 78
3. LESS (A) Est. Income and Victory Tax Withheld During Entire Year 1944	$ 240 00	
(B) Tax Paid March 15	$ 344 07	
(C) Tax Paid June 15	$ 406 40	$ 990 47
4. BALANCE OF UNPAID TAX (Item 2 Less Item 3)		$ 813 31
5. TAX PAID SEPT. 15 (Not Less Than ½ Item 4)		$ 406 41
FOURTH QUARTER		
1. Total Estimated 1944 Net Income (from Comparative Income Schedule)		$ 9800 00
2. Estimated Income and Victory Tax for 1944		$ 1977 98
3. LESS (A) Est. Income and Victory Tax Withheld During Entire Year 1944	$ 240 00	
(B) Tax Paid March 15	$ 344 07	
(C) Tax Paid June 15	$ 406 40	
(D) Tax Paid Sept. 15	$ 406 41	$ 1396 88
4. BALANCE OF UNPAID TAX (Item 2 Less Item 3)		$ 581 10
5. TAX PAID DEC. 15—Item 4		$ 581 10
FINAL TOTALS		
1. Actual 1944 Net Income		$ 9864 92
2. Actual Income and Victory Tax Upon Item 1		$ 1940 36
3. LESS Total of Withholdings and Quarterly Prepayments		$ 1922 28
4. DIFFERENCE TO BE PAID OR REFUNDED		$ 18 08

SUGGESTIONS

Item 1. Total estimated income from wages, salaries, dividends, interest, rents and all other sources including net income from your practice, farming, or any other business. Item 2—Total Income and Victory Tax—this must be figured upon forms furnished quarterly by the Bureau of Internal Revenue. Item 3—Income and Victory Tax Withheld—applies only to those who have wages or salaries from which deductions are made for this purpose. Final Totals—To be filled in after the 1944 income tax return is made out so that essential figures may be a matter of permanent record.

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'There's Nothing Wrong With You!'

Two G.P.'s discuss ways to manage the possibly neurotic patient

"I told her there was nothing physically wrong with her. Now I'm afraid I shouldn't have done it. Yet the fact remains, she was as sound as a dollar."

"Did you convince her of that?"

"I did not! She quit me and went to a chiropractor. They'll do it every time! . . . Under the circumstances, what would *you* have done?"

"Well . . . let's say a preliminary check-up shows nothing physically wrong. I then try to sit for a while and just talk with the patient. *He* thinks it's simply friendly conversation, but I'm actually looking for something that may give a clue to the trouble. Perhaps it's mental. I assume *something's* wrong or the patient wouldn't have come. Of course, this takes time; but it pays in the long run."

"Do you usually succeed in getting your clue that way?"

"Sometimes. Take the case of a woman who came to see me not long ago. She wasn't exactly sick, she said, but she hadn't been feeling up to par. I went over her quickly and couldn't find a thing. Finally we got to talking, and in the course of the conversation she said, 'Doctor, why is it I have to drink so much water?' There it was: a symptom of diabetes. A subsequent urinalysis confirmed it."

"But suppose your talk with the patient is unproductive. What then?"

"Well, I usually suggest a basal metabolism, X-rays, electrocardiograph, or whatever diagnostic procedure seems most likely to yield results."

"That's pretty expensive for the patient, isn't it?"

"Yes. It is. But would you prefer simply to let her worry about herself, winding up eventually, perhaps, in the hands of some cultist? Any physician worth his salt, it seems to me, is duty bound to pursue the solution of a case as far as he can."

"Maybe so; but lots of patients just *imagine* they're ill."

"I don't agree with you. I think that's only a half-truth. If there weren't something wrong with the patient, he wouldn't visit you. Maybe he *hasn't* one of the conventional ailments, but he still needs a physician's attention. The first thing you have to do is to be sympathetic, to listen to the

patient's story, to let him relate his family troubles or his financial problems. That's the only way to gain his confidence. As soon as he sees you're interested in him, he'll cooperate. He'll come back for other check-ups, if necessary. Then you can study his condition more closely. Subsequent examinations may turn up things you didn't find the first time."

"There's something in that. At any rate, I agree you've got to have the patient's confidence."

"Believe me you do. A psychiatrist once told me that plenty of people come to him when they don't need to—all because their own doctors fail to show enough interest in them. He claimed that the family physician could find out what's the matter in many questionable cases—just by asking more questions and listening harder. 'They're not *all* neurotics,' he told me; and I've never forgotten his remark."

"I once tried to get a woman patient of mine to see a psychiatrist and she boiled over at the very idea."

"True. They have to be handled with kid gloves. That's also the reason I never tell a patient to 'Forget about it!' If a woman tells me she doesn't sleep as well as she used to, or the kids are getting on her nerves, or she thinks she's not attractive to her husband any more, instead of saying, 'Oh, I wouldn't worry about that,' I say, 'Well, why not tell me more about it? Perhaps I can help you.' Maybe she's neurotic, maybe she isn't. That type of nervousness can be the first symptom of a lot of things. If I said 'It's just your nerves,' she'd go away frustrated. But if I encourage her to talk, I may get to the bottom of the thing. Just finding a sympathetic ear once in a while is medicine for some people."

"Well, at least when I told that last patient there was nothing physically wrong with her I didn't turn around and write out a prescription!"

"No. But, that very thing is done sometimes . . . Which reminds me to say that in my opinion most patients would rather be referred to some specialist than be told flatly that there's nothing the matter. At least that sustains their hope; and there's always a possibility that the specialist may actually be able to help them."

"What do you think of telling the patient to come back in a week or two if he doesn't feel any better?"

"That may be a good idea if you've prescribed something. But you must first win his confidence. You've got to get him to talk. You've got to listen, and listen attentively. You've got to ask questions—plenty of them. And you've got to give him a thoroughgoing physical check-up. You may also have to resort to some diagnostic tests. If all these things fail, the case then goes to a specialist . . . at least that's *my* method."

Your Legal Questions Answered

Duplicating patent medicines; contract practice; leases; other problems

Q. May a physician legally duplicate, in a prescription, the ingredients and proportions of a patent medicine?

A. Yes—provided he doesn't represent his prescription to be the patent medicine itself. The ingredients in a proprietary product may be used by anyone. It is the combination of ingredients, proportions, and name which constitutes the patent right. If one stops short of using the product name, he may legally duplicate the ingredients and the proportions.

Q. What are the criteria by which a court is guided in determining whether a medical fee is reasonable?

A. Usually the more important considerations are: (1) the fees charged by other physicians of equal standing in the same community; (2) the customary charges made by the claimant physician in similar cases; (3) the time consumed in rendering the services involved; (4) difficulties encountered in the case; (5) the professional standing of the claimant physician; (6) special abilities he may possess; and (7) the patient's ability to pay.

Q. I am associated (under a contract) with a group which guarantees me 30 per cent of its income. I am paid monthly by the group's business manager. Am I legally and ethically entitled to verify the group's income, or must I rely on the manager's figure?

A. If the contract is a legal and ethical one (*i.e.,* an agreement made with professional men, and not with laymen or with a lay organization), you are legally and ethically entitled to check all figures which form the basis of your 30 per cent compensation.

Q. When a physician answered the first questionnaire of the Procurement and Assignment Service, he had his first naturalization papers. Is he obliged to inform the P&AS when he gets his final papers? Also, must he notify his local draft board?

A. A doctor need not notify the P&AS, but under the rules of the Selective Service System, he *must* inform his local draft board of any such change in his status.

Q. For five years I paid $80 a month rent for my combined office and apartment in New York City. The landlord raised this to

$90 on the expiration of my lease, October 1, 1943. Had he the right to do this?

A. Yes. Professional space is classified as business property. As such, it is not subject to New York's ceiling regulations, which at present apply to living quarters only. Therefore, the landlord could properly maintain that the increase applied to that part of the premises used for professional purposes.

Q. (1) How often must a collection agency report on collections made? (2) In the absence of acceptable results, can the assigned accounts be withdrawn? How?

A. (1) When the contract between doctor and agency does not specify a definite period, the law infers that reports will be made at reasonable intervals, or within a reasonable time after collections are effected. The "reasonable time" is determined by the facts in the particular case.

(2) A doctor may withdraw his accounts at any time. He is liable to the agency, however, for services rendered up to the time of withdrawal. Sometimes the contract specifically states what this fee shall be; if it doesn't, the physician must expect to pay a reasonable amount. If collections are poor due to lack of diligence on the part of the agency, it may be possible for the doctor to withdraw his accounts without being liable for any fee; but such lack of diligence must naturally be proved.

All collection-agency contracts should be carefully read. Avoid contracts in which the doctor is liable for charges when no collection is made. Any vague or ambiguous phrasing should be deleted. Such matters as fees, monthly reports, the right to withdraw accounts, and methods of collection should be clearly and specifically stated. Be sure that you understand the agency's methods. An agency may make threats or use methods which not only embarrass the physician but also make him liable for damages. Remember that the agency represents you, and any act which you permit it to make is legally your own act.

Since there are many good agencies which require no contract at all, a physician may avoid all this necessity for caution by turning his delinquent accounts over to one of them.

Q. In our psychiatric and neurological clinic, with which fifteen physicians are associated, we hold regular staff conferences. Patients' histories are discussed in detail. Are we legally justified in inviting physicians, professors, and social workers to attend?

A. Such conferences are perfectly legal and ethical. It must be remembered, however, that each patient has the right to privacy—which may not be invaded without his permission. Hence it is important that no patient under discussion be identified. In the rare case where it's necessary to identify one, obtain the pa-

tient's written permission. Otherwise, the person who identifies him may be become liable to suit.

Q. I treated a patient for accident injuries and was asked later by his attorney for a certificate of expert opinion on the degree of disability. I agreed to furnish it after receiving the attorney's oral assurance that I'd be paid for my services. Later the case was settled and the lawyer received his fee; but he now insists that he owes me nothing—that I must look to the patient for compensation. Is the attorney liable?

A. If it can be shown that the attorney promised to pay the fee himself, he is liable. But if he merely assured you that you would be paid, and made no direct promise to pay you himself, he is not personally liable. If the contract between the attorney and his client shows that the lawyer agreed to pay all necessary fees incident to the suit, it would indicate that the attorney owes you the money for your services. In any event, the patient is liable, even if the lawyer isn't—inasmuch as the lawyer acted as the patient's agent. This obligates the patient for any reasonable expense incurred in the conduct of the suit.

Q. May a sixty-day-notice-of-removal clause in a house-rental contract be broken if a physician-tenant is suddenly ordered to duty with the armed forces?

A. The clause is binding. It probably was incorporated in the lease to cover the possibility of just such a call to duty. It serves two purposes: First, it permits the tenant to terminate the lease before the end of the lease period. Second, it compensates the landlord for this "concession" by giving him at least two months in which to obtain a new tenant; otherwise he might stand to lose several months' rent.

Q. I would like to return to general practice, following a period of total disability, as an aid to the war effort. However, I'd be forced to limit myself to office work in internal medicine. Can I legally and ethically limit my work thus without being certified in the field? To make my position clear, I'd hang this sign in my reception room: "Practice limited to internal medicine—office calls only." Would I be obliged to make outside calls on a patient once I had accepted him as on office patient?

A. A licensed physician may limit his practice to any field of medicine or surgery—he need not be certified by any board or authority. Likewise, he may limit his practice to office calls only, being careful, however, to inform each patient directly that he will be unable to make outside calls. Otherwise, possible malpractice suits may result and the doctor may be found guilty of negligence in not making a house call when so requested. The sign you describe is not sufficient notice; some patients may see it and others may not.

—JAMES R. ROSEN, M.D., LL.M.

The American College of Surgeons

Its relationship with other professional groups and its prospects for the future

The American College of Surgeons has kept its eye on the ball. It started out to elevate the standards of surgery, and by allowing nothing to distract it from that it has achieved its goal.

When the college was established in 1913, many regarded it as an intruding newcomer that might poach on the preserves of other organizations. Since then the ACS has demonstrated its ability to get along amicably with those groups. It has shown that there is a distinct field for its activities, and it has been careful to avoid duplicating the functions of others.

There have, of course, been instances of friction, but they have been infrequent. The most dramatic, perhaps, occurred in 1934 when the American Medical Association took sharp exception to an ACS report on health insurance and challenged the college's right to speak for the profession. The ACS had released a statement advocating the encouragement of periodic prepayment plans for medical and hospital service, with hospital participation limited to institutions approved by the college. Two days later the AMA House of Delegates adopted a resolution asserting that "the American Medical Association... is the only democratic body representing the organized profession of this country," and condemning "this apparent attempt of... the American College of Surgeons to dominate and control the nature of medical practice." The resolution ended with a demand that the board of regents of the college be called upon to "explain the reasons for their action and to justify the attempt by this small group within a specialistic organization to legislate for all the medical profession of this country, truly represented only by the American Medical Association."

Ill will generated by this tiff between the two bodies was gratifyingly short-lived. The exchange of blows may even have

¶ This is the last in a series of three articles on the American College of Surgeons. The first (see August issue), dealt with the college's organization, history, and membership. The second, which appeared in September, described its major activity—hospital standardization.

helped in the long run by giving the participants a chance to dissipate their pent-up antagonism. In any event, they soon made up and by 1939 were cooperating actively.

Besides using the same questionnaire to obtain data from hospitals, each now indicates on its own list of approved hospitals the names of those which have been approved by the other. The present chairman of the ACS board of regents, Dr. Irvin Abell, is a former president of the AMA, and the immediate past-president of the AMA is a fellow of the ACS.

The college has always gotten along smoothly with the two leading hospital groups: the American Hospital Association and the Catholic Hospital Association. Both were approached when the college first drew up its hospital standardization program, and both gave it enthusiastic support. Close friendship with the AHA is enhanced by the fact that Dr. Malcolm T. MacEachern, associate director of the college, was once president of the hospital association. Because it has helped raise the standards of specialized personnel working in hospitals, the ACS enjoys the support of organizations of hospital administrators, nurses, medical social workers, pathologists, technicians, medical record librarians, and others.

There is also an intimate relationship between the college and some of the specialty boards. Practically all the boards concerned with surgery and the surgical specialties are headed by ACS fellows. The college has three representatives on the American Board of Surgery, one on the American Board of Neurological Surgery, and one on the American Board of Plastic Surgery. It is not, however, represented, as an organization, on either the American Board of Orthopedic Surgery or the American Board of Obstetrics and Gynecology, despite the fact that many of its members practice these specialties. (The American Board of Surgery, incidentally, relies heavily upon the college's rating of hospitals suitable for graduate training in surgery.)

The college also maintains contact with local medical societies. These are called upon periodically to supply information about hospitals under investigation by the ACS. Extremely close cooperation exists likewise between the college and a number of cancer organizations. For example, the women's field army of the American Society for the Control of Cancer has adopted a policy of referring patients to cancer clinics approved by the college; and the National Advisory Cancer Council recently granted the college $7,500 to carry on cancer research. The college works actively, too, with such groups as the American Committee on Maternal Welfare and the Council on Rehabilitation.

Other evidences of cooperation

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MINIT-RUB does much to help ease the "tightness" and discomforts due to colds affecting the upper respiratory passages. Stimulation of the local blood supply brings soothing, relaxing warmth, aids in relieving congestion, and alleviates surface back and chest pain. MINIT-RUB benefits go beneath the skin through reflex action. It is also a prompt and useful aid in the treatment of simple neuralgias and myalgias . . . Literature on request.

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appear in the administrative structure of the college. More than a score of surgical associations and societies* are eligible under ACS by-laws, to nominate one man each as a candidate for the ACS board of governors. One observer has commented that in a sense the college is an amalgamation of all medical societies interested primarily in surgery. It certainly cannot be denied that it is the largest and the most articulate, and that it has the machinery, which many smaller groups lack, to further its program.

The college's position of authority is made possible by a number of factors: It is young enough (only thirty) to retain a good deal of vigor and enthusiasm, and old enough to have attained the balance that comes with maturity. It isn't hampered by the traditions that sometimes obstruct the progress of older groups. Yet it is by no means radical in its approach to socio-medical problems.

Unlike some select groups (*e.g.*, the American Surgical Association), the college opens its doors to all surgeons who can meet certain established standards. That these are not impossible of achievement is indicated by the fact that the college now has more than 13,500 fellows. It is, therefore, a democratic organization offering the benefits of membership to the largest possible number of surgeons. It cannot be accused of snobbishness.

Since the college does not enter into serious competition with other professional organizations, there are few causes for conflict. True, its chief activity, hospital standardization, is engaged in to some extent by other groups, notably the AMA. But the college is the only organization that rates hospitals on the basis of their ability to provide adequate service to the community. The AMA and others are concerned primarily with the teaching, training, and employment facilities of hospitals.

The personality and standing of Dr. MacEachern cannot be overestimated in any evaluation of the college. The 62-year-old Scotsman enjoys a wide reputation as an authority on hospital administration, and has behind him many years of practical experience as a hospital superintendent. He was graduated from the McGill University Faculty of Medicine (Montreal) in 1910, and he holds both a D.Sc. in hospital administration and an M.D.

*These organizations include the American Surgical Association; the American Gynecological Society; the Southern Surgical Association; the Western Surgical Association; the Pacific Coast Surgical Association; the American Association of Obstetricians, Gynecologists, and Abdominal Surgeons; the American Orthopedic Association; the American Academy of Orthopedic Surgeons; the American Association for the Surgery of Trauma; the American Association of Genito-Urinary Surgeons; the American Urological Association; the American Laryngological Association; the American Ophthalmological Society; the American Otological Society; the American Academy of Ophthalmology and Otolaryngology; the American Institute of Homeopathy; the medical corps of the Army and Navy; the section on surgery of the Canadian Medical Association; and certain sections of the AMA (*e.g.*, those on surgery; ophthalmology; obstetrics, gynecology, and abdominal surgery; and laryngology, otology, and rhinology).

Although not now in active practice, he is certified by the American Board of Obstetrics and Gynecology. He is a member of the American College of Physicians and of both the AMA and the Canadian Medical Association.

The college got off on the right foot in 1913 by being meticulously careful not to give the impression that it was a Chicago-inspired project, although most of the founders lived there. In line with this policy, Dr. John M. T. Finney of Baltimore was elected as its first president.

The determination of the ACS to raise the standards of surgery has given it broad appeal among the medical profession and hospitals as well as among the laity. The college's campaign against fee-splitting, however dubious its success, has met with widespread public and professional sympathy.

Opposition to fee-splitting has always been a compelling issue with the college. Dr. Franklin H. Martin, founder of the ACS, complained in his autobiography that "The problem of combating the division of fees had become an obsession with many of our founders. Innumerable letters recommended that it should become the principal object of the college, and that we should virtually 'wash our dirty linen in public.'" Later, in describing the first meeting of the board of regents he went so far as to complain that "The principal discussion of the evening bore upon the omnipresent question of fee-splitting . . . Any suggestion that we had other important business to transact did not command attention."

Although the fee-splitting issue has not since been allowed to overshadow the broader goals of the organization, it is still a vital one. Candidates for fellowship are required to sign a declaration against indulging in the practice. They must repeat their promise when they take the fellowship oath administered at the initiation ceremony. The by-laws give specific authority to the board of regents to expel any fellow who violates his pledge. The college even specifies that no hospital can win an approved rating unless its staff members sign a pledge against fee-splitting.

Dr. Martin was extremely cautious in his treatment of the issue because he feared that a blazing crusade against fee-splitting might provide fuel for the enemies of the college. "Naturally," he wrote, "those who were opposed to our ideals would seize upon this intensive propaganda to place us in a ridiculous position." He got his way, but even today the college takes a stronger stand in this regard than do most other professional groups and organizations.

Although observers seem to agree that the American College of Surgeons occupies a dominant role today, there are conflicting views as to its future. On the one hand, it is argued that the college will continue to grow while

some of the older groups may decline. This view is held by Oliver Garceau, who suggests in his "Political Life of the American Medical Association" that organizations like the ACS may well develop at the expense of the AMA. Garceau points out that "the AMA is faced with real competition for the loyalty and support of the profession," and adds that "The American College of Surgeons and the American College of Physicians have already become forums for the airing of dissenting views."

On the other hand, some critics believe that the college fulfilled its mission when it inaugurated hospital standardization, and that its further growth is checked by the increasing influence of the American specialty boards. The latter, according to this view, are setting standards for surgeons that are beginning to carry considerably more weight than membership in specialty organizations. It is argued that certification by the American Board of Surgery is a far more valuable asset to a surgeon than an FACS after his name.

The facts, however, do not appear to support either of these rather extreme viewpoints. They are based, apparently, on the assumption that the ACS is in constant conflict with the AMA and with the specialty boards. Yet, actually, as has been pointed out, the area of competition is slight. The college is a specialty organization carrying on a number of functions which are not the concern of the AMA. The two groups operate in entirely different fields.

Nor is there any essential conflict between the college and the specialty boards. The outstanding contribution of the ACS has been its work in raising hospital standards, a task which is beyond the province of the boards. The latter are concerned exclusively with determining whether specialists are genuinely qualified to practice in their chosen fields.

This division of responsibility was recognized three years ago when the ACS board of regents met with representatives of the surgical boards to discuss coordination of their activities. It was agreed at the time that the college's program for standardizing graduate training in surgery was an important step in preparing men for certification.

One observer has even pointed out that the organization of the specialty boards was the logical outcome of years of pioneer work by the ACS.

Today the ACS includes practically all competent surgeons in the United States and Canada. Its efforts to improve surgery have been hailed even by those who are not particularly friendly to the college. Its financial basis is sound, its prestige and influence are unchallenged. As is the case with many another organization, its future will depend in large measure on the caliber of its leadership. —GEORGE B. FRITZ

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Nine years of continuous research provide the clinical background for *Ertronization* as the method of choice in arthritis management. Numerous favorable reports on ERTRON from leading arthritis clinics, universities and private practice have appeared in the literature.† As evidence resulting from ERTRON research accumulates, this important form of therapy constantly becomes more and more firmly established.

†*Complete bibliography and mode of administration available on request.*

Color Cues for Your Office

Some down-to-earth ideas on an up-in-the-clouds subject

Coach Alonzo Stagg of the University of Chicago once designed two dressing rooms for his football teams. One room, done in stimulating colors, was used for pep talks before games. The other, in soothing hues, helped the players relax between the halves. Color schemes of both the rooms were copied from those employed for mood control in a mental hospital.

Physicians might well consider this coach's functional use of color when having their professional offices decorated. For one thing, it can give a mighty "lift" to the patient who has spent the day in dreary surroundings and who feels physically unhappy as well. For another, it can help cheer the regular occupants of the office: the doctor and his nurse.

Give a thought to these specific suggestions:

When planning an office room with a view to color, remember to take into account (1) the psychological effect on patients, (2) exposure, (3) amount of natural light present, (4) type of furnishings.

If there is a "best" color, psychologically, for the professional office, it's probably light green—nominated because of its restfulness. Pale gray is a soothing second. Tints* of blue while likewise quieting to the nerves, may have a depressing effect, and cannot be recommended too freely for that reason.

Least soothing are red, orange, and yellow; however, certain tints of these are not hard to get along with and may be worth using if restfulness seems less important than brightening otherwise drab quarters. Such tints include dusty rose, peach, and gold.

Although a good many colors are generally taboo in medical-office decorating—*e.g.*, red, because it is too exciting and blue because it is too depressing—these colors can still be employed to excellent effect as accents. The trick is to use them sparingly and plot them dramatically against subdued backgrounds.

If a room faces South or West, and therefore gets a good deal of sunlight, it is well—other things being equal—to use so-called "cool" colors in it. Usable cool

*Just in case you've forgotten: *Hue* means color. *Value* indicates lightness or darkness. A light color is called a *tint;* a dark color, a *shade.*

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In influenza nature heals while the doctor relieves. In DERFULE Capsules you have an effective means of keeping your patient comfortable and in good spirits during the natural course of what might otherwise be a most distressing illness.

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Dover's Powder (containing 10% powdered opium)	¼ grain
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colors include green, orchid, and most grays. "Warm" colors, for rooms facing North or East, include beige, gold, peach, and rose.

Cool tints of desirable green and gray need not be ruled out entirely for rooms with a Northern or Eastern exposure. But be sure to counteract their coolness with touches of warm color.

The reason for emphasis on exposure is, of course, that rooms facing North and East get relatively less light than rooms facing South and West. Warm colors reflect light while cool colors absorb it.

One of the commonest errors when using colors in decorating is to try to combine antagonistic hues such as a blue-green rug and a yellow-green sofa, a yellow chair and a beige wall, or pink wainscoting and ecru doors. Another error is to select and employ indiscriminately such harsh commercial shades as Royal Blue, Kelly Green, and vermilion.

No matter what colors are combined in a room, one of them should predominate. Such a color base makes for coherence and emphasis and gives the room character.

There is no reason why you can't have a different color scheme in each room. However, it is wise to avoid differences in rooms that open off each other unless the colors in question dovetail.

Despite improvements in manufacture, some paints still fade. Be sure you get one that won't; otherwise your color scheme may be out of balance a few years after you decorate.

Remember, too, that artificial light affects colors considerably. Blue looks gray, gray turns slatey, green gets duller and yellower, pink becomes peach, yellow seems brighter, and peach and dusty rose appear beige. It is advisable to get large samples—at least fifteen inches square—of each color contemplated before you finally decide on a color scheme. Then, under both artificial and natural light, you can match the samples with your draperies, upholstery, and floor to see whether the blend is harmonious and achieves the effect you want.

Base most color schemes on three colors, perhaps using a touch of a fourth as a decorative accent. Subdue large masses of ceiling, floor, and wall.

Following are some color combinations for doctors' office rooms. Selection should be based on the principles outlined in the preceding paragraphs.

A

Walls—pale green
Woodwork—white
Draperies—green flowered
Floor covering—dark green
Accents—red (use sparingly)

B

Walls—dusty pink
Baseboard—blue-black
Other woodwork—dusty pink
Floor covering—blue-black
Draperies—white, blue-black edging
Accents—white [*Turn the page*]

C

Walls—pearl gray striped
Woodwork—gray
Draperies—dark green
Floor covering—rose
Accents—yellow

D

Walls—oyster white
Woodwork—light gray
Draperies—dark blue figured
Floor covering—medium blue-gray
Accents—white

E

Walls—yellow-gold
Baseboard—black
Other woodwork—yellow-gold
Floor covering—black (plain or marbleized)
Draperies—yellow-gold and red

—PAUL J. PALMER

Interne Policy

[*Continued from page* 47]

women and physically disqualified men.

In general, hospitals will have to get along next year with about two-thirds the number of residents they had in 1940, and with from two-thirds to three-fourths the number of internes. These figures include men disqualified for military service as well as commissioned doctors who will be deferred.

Two-thirds of all presently commissioned internes may be ordered to active duty about January 1, 1944, when new graduates will begin their interneships. Residents in many hospitals, meanwhile, have been deferred only until July 1. When they leave, therefore, these hospitals will have to get along with unusually depleted staffs for three months. In cases of severe hardships the P&AS will attempt to assist hospitals during this period.

The P&AS has instructed all hospitals to submit analyses of their present status. Using these, the service will set up quotas for each hospital and for each state. States will not be allowed to exceed their quotas, although adjustments within state borders will be permitted. For example, an interne who receives deferment may move on to another hospital to serve as assistant resident.

—EDWARD STONINGTON

LEADING RAIL EQUIPMENT STOCKS

Earnings—Dividends—Market Prices

	Earned Per Share 1941	1942	*Dividend* 1942	*Price Range* 1943	*Recent Price*
American Brake Shoe	$3.56	$ 3.22	$1.70	43¾—27⅝	37¼
American Car & Foundry	5.23	12.09	4.00*	45½—24¼	34¼
American Locomotive	4.12	3.37	...	17½— 7¾	13
Baldwin Locomotive	3.71	4.23	1.00	19¾—10¾	16½
General American Transportation	3.75	3.27	2.00	51 —37	43
General Railway Signal	2.06	2.45	1.25	25½—12⅜	20½
Lima Locomotive	6.02	7.79	2.00	44 —24	34¾
Pressed Steel Car	1.09	2.18	.50	13⅜— 6⅜	11¼
Pullman, Inc.	3.31	3.14	3.00	40⅛—26¾	34¼

*Paid this year.

RAILROAD EQUIPMENT SHARES

Investors see the industry preparing for heavy civilian production

The railroad equipment industry has long been a feast or famine business, directly reflecting the ups and downs of its customers, the railroads. Its present feasting period, however, gives promise of continuing for an abnormally long time, thus postponing the next famine indefinitely. At least three factors bolster this belief.

1. Railroads here and abroad will need vast quantities of new equipment of the latest design to hold their position in the post-war transportation field.

2. During the war, the industry has been developing profitable new lines.

3. Steps have been taken by certain companies to set their financial houses on sounder foundations.

LOCOMOTIVES

In the field of locomotive building, represented by American Locomotive, Baldwin Locomotive, Lima Locomotive, and General Motors (in the Diesel field), there is now a huge demand. Supply is limited only by material allocations, which are gradually becoming more liberal.

The chairman of American Locomotive says that on August 1 the nation's railroads had 42,111 locomotives in service—a decrease of 738 in a year despite the construction of 1,200 new units in the same period. Retirement of worn-out power units under war usage is far exceeding replacements, so it appears probable that post-war rehabilitation of rail properties to handle normal traffic will require a continuation of locomotive building on a large scale.

The industry also expects foreign demand for rail equipment to be a big post-war factor. Bombing of European manufacturing centers has already reduced locomotive production facilities abroad; with the result that companies like American, Baldwin, and Lima will have to step into the breach.

There are indications in the locomotive field, at least, that war orders are now declining and civilian business is again coming to the fore. One company notes that at the start of September its unfilled orders, amounting to some $400,000,000, represented 55 per cent armament and 45 per cent other business. Ear-

lier the armament ratio had run as high as 90 per cent. Slowing up of tank construction accounts for the change.

Within the locomotive industry there is a strong competitive situation: Diesel power versus the traditional steam locomotive. At least one railroad has Diesels in every branch of its service and another is studying the possibility of using nothing else. This has brought about the entry into the Diesel field of companies formerly devoted exclusively to the manufacture of steam units.

These companies, while admitting the advantages of Diesel power, are continuing to build steam locomotives and have made great improvements in them. Considering first cost and efficiency of operation, it seems unlikely at this point that Diesels will push steam completely out of its traditional field.

FREIGHT CARS

Freight car manufacture, the other major staple in the rail equipment business, has also been curbed by the war. The conversion of plant facilities to armament manufacture has increased steadily the demand for new rolling stock. Supply has also been limited by material and manpower shortages, with the result that the backlog of potential business continues large.

In the first eight months of 1943 the railroads put only 15,744 new freight cars into service, contrasted with 53,695 in the same period of 1942. As the armament load tends to lighten, the normal building of cars should of course be resumed. Not only will the demand be there, but the carriers will be able financially to make big purchases once again. Construction in other periods has run to 70,000 or more freight cars annually.

The transition from old-time wooden boxcars to modern, lightweight, steel cars, capable of greater payloads, seems likely to continue after the war. It is hoped that present standardization of design will also continue.

PASSENGER CARS

Passenger car building has been at a standstill for months, even in the face of the greatest passenger load ever carried by the railroads. Perhaps the demand for this kind of equipment may not be so great after the war as it is now, because of renewed and increased competition from highway and air carriers. There are definite indications, though, that streamlined trains, the showpieces of the railroad business, will grow in number and popularity, and that improvements like air conditioning, as well as changes in the design of Pullman equipment, may contribute at least a fair-sized program of passenger car construction.

In the building of cars, both freight and passenger, the leaders are American Car & Foundry and Pullman-Standard (a unit of Pullman, Inc.). There are also specialized builders like General

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Three daily servings (1½ oz.) of Ovaltine provide:

	Dry Ovaltine	Ovaltine with milk*
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CARBOHYDRATE	30.0 Gm.	62.43 Gm.
FAT	2.8 Gm.	29.34 Gm.
CALCIUM	.25 Gm.	1.104 Gm.
PHOSPHORUS	.25 Gm.	.903 Gm.
IRON	10.5 mg.	11.94 mg.

	Dry Ovaltine	Ovaltine with milk*
VITAMIN A	1500 I.U.	2953 I.U.
VITAMIN D	405 I.U.	480 I.U.
THIAMINE	.9 mg.	1.296 mg.
RIBOFLAVIN	.25 mg.	1.278 mg.
NIACIN	5.0 mg.	6.9 mg.
COPPER	.5 mg.	.5 mg.

*Each serving made with 8 oz. milk; based on average reported values for milk.

American Transportation. Competition is not lacking in the car building field, particularly in the bid for streamlined train improvements. In this, the E. G. Budd Manufacturing Co., whose operations were once confined largely to the automotive field, has become a major factor.

OTHER PRODUCTS

Under stress of war, makers of railroad equipment have turned to volume production in other branches of the heavy-goods industry. The synthetic-rubber program, for example, requires heavy machinery which the rail equipment companies are able to build. A subsidiary of American Locomotive is already the largest maker of the heat-transfer equipment used in new rubber plants as well as in oil refineries and chemical plants.

Increased output of some older products is also likely, notably equipment for centralized traffic control. The latter makes possible more efficient use of the single-track railroads which constitute much of the nation's mileage. In 1942 and in the first half of 1943 it is estimated that centralized traffic controls was installed on 2,000 miles of line, against a total of 2,702 miles in the entire preceding fifteen years. Principal companies in this field are General Railway Signal and Union Switch & Signal (a subsidiary of Westinghouse Air Brake). Patents are pooled.

FINANCIAL PROSPECTS

Given an adequate volume of business, the rail-equipment companies can earn a good return for their investors. This has been abundantly demonstrated in years of railroad prosperity and again in the present war era. Added to that, a number of companies have recently been getting ready for post-war production by arranging for loans to protect their capital structures. Pullman has contracted for a loan of $60,000,000, which it feels will permit it to get back into the manufacture of badly needed peacetime equipment with minimum interruption of employment and production.

Elimination of preferred dividend arrears by American Locomotive in a recent plan of adjustment is another example of the forward-looking financial policies being adopted now by the equipment makers. American Car & Foundry has been able to resume common dividend payments in the war years. E. G. Budd has replaced a high-dividend preferred with a lower-rate issue.

—FRED B. STAUFFER

Ways to Cut Fuel Consumption In Your Home and Office

Here are some hints that will help reduce heating costs a third

Remove radiator covers for the duration. Most of them prevent proper radiation.

Put a reflecting shield behind each radiator; it will prevent heat from being absorbed by the wall and will reflect it out into the room. Aluminum foil in sheet form is good for this purpose, and is still stocked by some dealers.

Refinish your radiators with oil paint rather than the metallic kind. You'll get from 10 to 15 per cent more heat.

Be sure radiators are level; otherwise pipes won't drain properly and circulation will be impeded.

Keep your windows locked when they're closed; locked windows fit more tightly.

Keep shades drawn in unused rooms (except when the sun is shining directly into them). The still air between shade and window panes is good insulation.

Keep sleeping rooms unheated day and night. Weatherstrip the doors leading into them so that cold air does not escape to other parts of the house. Also equip these doors with springs so they'll always close tightly.

Turn off radiators when you ventilate any room.

Take advantage of "free" heat. One source is sunlight; raise your shades and let it in whenever its available. Another source is the equipment in your office.

If a room gets too warm, don't open the windows; turn off the radiators.

Be sure service openings—coal chute, basement doors, windows, etc.—are kept closed when not in use.

Close fireplace damper when fireplace is not in use; if it has no damper stuff the chimney with paper.

If you have a basement garage be sure its door closes snugly.

If you burn anthracite coal buy two sizes: "stove" and "chestnut." Use the larger stove coal in exceptionally cold weather and a mixture of stove and chestnut during milder spells.

If you fire by hand observe these precautions: (1) Keep the ash pit clean; (2) keep the firepot full; (3) don't use the fire door to regulate the draft; (4) add coal to the fire after poking but before shaking. [*Turn page*]

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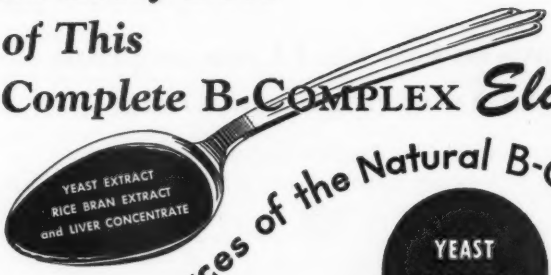

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Hire an expert to put your heating plant in order. He'll see that grates or burners are in good condition, dampers and controls properly set, valves open and efficient, chimney and flue pipe clean and in repair. Have him place asbestos insulation wherever necessary.

Hire a carpenter to close all holes and crevices through which cold air enters. Have him fit outside doors properly, check for openings around foundation and sill of building around window frames, and in the attic where studding joins the roof.

Install storm windows if you can still obtain them in your section.

Weatherstrip loose-fitting windows and doors. Metal stripping costs more than felt or rubber but it's more permanent.

Insulate the roof and sidewalls, and beneath the ground floor (especially if part of basement is excavated but unfinished).

—A. P. KEARNEY

The Halogen Kids

[*Continued from page* 63]

could almost promise her a boy. As I entered her room and set down the two heavy grips, it was quite evident we should not have long to wait. In a few minutes the stillness of the night was rent with a lusty, "Waah!"

"What a pair of lungs that boy has!" I exclaimed.

"Is it a boy, Doctor, sure enough?"

I glanced at the howling infant. It was *not* a boy.

To avoid answering, I busied myself with hypodermic syringe and pituitrin ampoule, but no words were needed to convey the sad tidings to Utility. She turned her face to the wall.

"Name it anything you want to, Doctor; I don't care what you call this one!"

My pen seemed to move over the surface of the birth certificate without my guidance. Like a Ouija board, it wrote the newborn's name: "Bromine"!

Mutely I walked out into the darkness, thinking that I could count on one thing: I had rendered my final obstetrical service to Utility.

The passing of another year proved me a false prophet. When the call came, I set out with trepidation and entered the patient's bedroom with fingers crossed. The charm was impotent; Utility had precipitated—Girl Number Four.

"Four in a row!" the mother groaned. "You can name this one, too . . ."

It was a tantalizing, uncomfortable feeling I experienced. For the life of me, I could think of but one name. I tried to force it out of my mind, damning the imp within which had inspired it. But it reverberated in my brain. Then it seemed I heard the voice of my old chemistry professor

droning from the dim past: "The four elements known as halogens —fluorine, chlorine, bromine, and . . . iodine." Florine, Chlorine, Bromine, and——!

"Utility," I heard myself say, "there's only one name for this girl."

No response.

"It rhymes."

Curiosity got the better of her. "What is it?"

"Iodine."

There followed a gloomy silence. Then she spoke.

"Yes, sir, it do rhyme pretty. I like that name—but it don't fit this child. Look at her. You can't call *her* 'Iodine.' *She* ain't no brownskin. That gal is *high-yellow*!"

She was undeniably right; no debate was possible, so I said nothing.

Then suddenly she exclaimed. "I got it! Write it down, Doctor, quick! We call her Bromine."

"But we named last year's baby Bromine," I objected.

"Then we changes it!" Utility was determination personified. "That brownskin child I had last year—*that's* Iodine. This here sweet little yellow gal is Bromine. Now we got 'em named! Ain't you happy, Doctor?"

"Yes, indeed, I'm happy," I replied. "And now I'm going to make you happy, too."

Utility stared uneasily. "How you goin' to do that?"

"This one," I replied, holding up the synthetic Bromine, "is on the house!" —ALLEN D. REBO, M.D.

Societies Warned Not to Exclude Membership Applicants Unjustly

Hospital staffs also cautioned against taking arbitrary or prejudicial action

A number of state medical associations have received complaints in recent months from physicians who say they have been denied membership in county medical societies and on hospital staffs purely because of prejudice against them. Of timely significance, therefore, is a current declaration of policy by the Ohio State Medical Association. Three component parts of the problem are discussed—two of them dealing with membership in county societies, the third with membership on hospital staffs.

1. Several licensed physicians who complained that their applications for county society membership had been arbitrarily rejected appealed to the state association to intercede. The association's committee on judicial and professional relations studied the situation for a number of months, and then released its findings.

The county society, this committee holds, is and should be the only judge of the qualifications of an applicant for membership. Nevertheless, it warns against abusing this power and taking "prejudicial action on a question of such vital importance," adding that, "our democratic form of organization could be destroyed by unwise action on the part of those who enjoy the benefits of membership."

The state medical association recommends specifically that when the county society is considering a doctor for membership, it measure the applicant with the yardstick set up by the state association in its by-laws. "Obviously," it says, "the candidate's ethics, moral character, and general reputation in the community must be carefully investigated, but such investigation must be conducted from an impersonal viewpoint and in a fair, democratic manner. We are not advocating that a county society let down the bars to those who are incompetent or unqualified but we do appeal to all county societies to use sound judgment and fair play in such procedures."

For the man who has not lived in a community long enough to have established a reputation, the state association recommends a probationary membership. During the probationary period, it

feels, the physician will have an opportunity to become acquainted with the accepted customs and practices of the community and to seek the advice and counsel of members of the society.

2. Complaints were also made that several county societies had adopted a blanket policy closing their membership for the duration of the war and for six months thereafter. The state society "strongly condemns" any such freezing of membership. It warns against unfavorable public reaction and urges that every candidate be judged on his own merits.

"It has been stated," the society declares, "that the primary reason for this [closed-membership policy] is to protect the status of the men who have made a great personal and financial sacrifice by entering active military service. This argument does not appeal to us as either sound or logical. In the first place, barring a licensed physician from membership does not in any way preclude him from locating within a county and engaging in the practice of medicine. Secondly, it is known that many physicians when discharged from military duty do not return to their former locations."

3. The third charge of prejudice brought before the state society concerned admission to hospital staffs. Here also the right of each institution to decide who shall be eligible is affirmed, but again the society recommends that every candidate be judged solely on individual merit. A physician who is incompetent, immoral, or unethical, it believes, should of course be excluded from the staff of any hospital whether or not he is a member of the county medical society. But where a practitioner has been refused medical society membership because of some obscure reason or because of a policy of blanket exclusion, this rejection should not be used as an excuse to refuse him hospital privileges.

"It is true," says the society, "that in most instances, a physician who fails to receive the approval of a county medical society is in all probability not qualified for membership on a hospital staff. However, there may be, and probably are, exceptions to this general observation, which puts it squarely up to the governing officials of a hospital to decide each case on its merits."

The Ohio State Medical Association declares that the complicated questions confronting the profession in wartime, and those inevitable in the period of postwar adjustment, cannot be successfully attacked "if so many of our members continue to take an individualistic attitude toward affairs which are of such vital concern to the profession as a group." Its statement concludes with a recommendation for the admission of all eligible physicians to membership and for the subordination of selfish considerations to unity of purpose and action.

—ELIOT EGAN

Beating the High-Income Jinx On Medical-Service Plans

Provision for "over-income" wage-earners eliminates obstacle to enrollment

Prepayment medical-service programs which set income limits as a condition of participation have found the going rough. In Pennsylvania, for instance, both management and labor were once reluctant to assist field workers attempting to enroll employes in what was otherwise a sound nonprofit plan. Management contended that a wage limit antagonizes organized labor, and may induce disputes. Supervisors—whose aid is invaluable in enlisting workers—lost all enthusiasm for the plan when they learned they were barred from its benefits. To complicate things, wartime wages disqualified workers who ordinarily would have been eligible.

Such was the experience of the Medical Service Association of Pennsylvania. Organized by the State Medical Society in 1939, the service provides (through participating physicians and only in hospitals):

1. Surgical services (including operative procedures) for the treatment of disease and injuries and treatment of fractures and dislocations) 2. Obstetrical services and postnatal treatment during the period of hospitalization, up to twenty-one days.

Income ceilings were fixed at $30 a week for single persons, $45 for married couples, and $60 for families. But these limitations hindered field workers to the point that it appeared the plan would have to be abandoned unless provision could be made for including persons whose incomes exceeded the limits.

Accordingly, last May, the service was authorized by the state legislature to amend its plan to include persons whose average weekly incomes exceeded the above limits.

Thus, enrollment is now open to "over-income" subscribers under an arrangement by which they receive full service benefits but themselves pay the participating physician a supplementary fee, consisting of the difference between his normal fee and that which he receives from the association in accordance with the latter's schedule.

Similar dual-group programs are now being successfully operated by other prepayment services also. —DENMAN NORTH

The Newsvane

No Goldfish

"Send books and magazines, and save the flowers and goldfish until the patient gets home."

Thus the Blue Cross advises visitors—on placards posted in seventy-six voluntary hospitals in New York City. Certain gifts require care on the part of hospital employes, and such employes are scarce, the service explains.

"Examining" Racket

The old "examining doctor" racket appears to have been revived by some insurance salesmen on the West Coast. The salesman invites a physician to examine new members of a fraternal group at an attractive fee. The catch is that the physician must join the organization and take out one of its group insurance policies. The doctor may actually examine one or two members, but he eventually finds that he has simply bought himself some more insurance.

Post Damns Wagner Bill

Advocating the expansion of group medical service, with federal support where needed, instead of "some New Deal miracle of unlimited promise and meager performance," The Saturday Evening Post has voiced opposition to the medical and hospitalization features of the Wagner-Murray-Dingell bill.

"From the ambitious nature of the scheme," a Post editorial says, "one might conclude that American medicine had never done anything for the indigent and that the one thing necessary to guarantee good health to all was the creation of a vast scheme for state medicine with more billions to spend than was considered necessary to run the whole country fifteen years ago.

"Actually, of course, the facts are just the opposite. Although so-called 'organized medicine,' as represented by the AMA bureaucracy, has often failed to respond to the demand for wider distribution of medical care, the history of American medicine is a consistent record of expanded service, scientific advance, and social responsibility. All the way from the country doctor, who needs no federal salary to get him out on a baby case at three in the morning, to group schemes like the Blue Cross hospital-payment plan, American medicine is trying to meet the health needs of the country.

"There is still need for progress in rural communities and among the poorer groups, and some medical societies still fail to see the advantages to the profession in prepaid medicine. But the trend is unmistakable and it would be tragic to divert it into politico-bureaucratic channels . . .

"Group medical service is growing rapidly around hospitals, business and industrial establishments, local political entities, and so on. To us, such schemes, with federal

support where needed, seem the reasonable way to bring about whatever changes are necessary in medical practice—natural evolution as opposed to some New Deal miracle having the typical political characteristics of unlimited promise and meager performance."

Statewide VD Tests

Alabama has launched a venereal-disease control program calling for the eventual examination of every person in the state between the ages of 14 and 50. Though blood tests for all such persons are required by a 1943 state law, the state department of health will be permitted to develop and expand the work gradually as facilities and personnel are available on a county-by-county basis.

Women Medical Officers

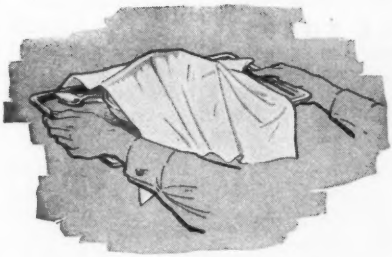
There have been few requests for commissions in the medical corps of the Army and Navy by women doctors since they won their fight for eligibility. According to Maj. Margaret D. Craighill the first woman commissioned in the Army Medical Corps, the Army "feels miffed" that more women have not applied.

"There was an awful howl to get commissions for women," she observes, "but so far only twenty-seven women doctors have been commissioned by the Army."

Industrial Practice Survey

Troubled by increasing absenteeism in war plants, the Procurement and Assignment Service has launched a nationwide survey of physicians in civilian life to determine how many are available for industrial practice and which men of military age might be replaced by older or physically disqualified men. The P&AS also wants to know how many doctors are willing to take special courses in industrial health and hygiene as a preliminary to industrial work.

Questionnaires began going out to doctors about mid-August, but results are not yet fully tabulated. The P&AS survey was facilitated by the American Medical Association, which asked state societies to distribute questionnaires. Some societies mailed them directly to doctors; others reproduced the form in their publications, with a request that members fill it out and return it to the society. It is by no means certain, therefore, that replies will



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be received from all physicians.

Just what the P&AS will do when the results are in is not clear at this writing. Presumably, qualified doctors will be urged to accept appointments in plants where the need is most acute.

The P&AS admits that the problem is a knotty one because of the severe strain placed on the supply of physicians by the armed forces and by civilian needs. It is probable that a solution will be sought by urging qualified doctors to do a limited amount of part-time work. Those who signify a willingness to take industrial medicine courses will probably also be asked to devote a few hours a day to near-by war plants.

It is significant that a number of questions asked doctors dealt with part-time industrial practice. For example, physicians already working part time in this field were asked to indicate what percentage of their time is spent in this manner. It may be possbile, therefore, that the P&AS intends to urge part-time men to go into industrial medicine on a full-time basis for the duration, especially in areas where absenteeism is most acute.

TB Tests Speeded

Extensive use of 35 mm., 46 mm., and 4" x 5" films for X-ray examinations has paved the way for tuberculosis surveys on a large scale among war workers and their families according to the U.S. Public Health Service. The PHS now has eight 35 mm. units on loan to state and city health departments for operation in war industries, and two 4" x 5" units for special projects. Preference is given to requests for service to shipyards, ordnance plants,

"There is probably no more valuable drug mentioned in any pharmacopeia than oleum alii, the active oil of garlic ... Any substance recommended for general use in so many diseases must be looked upon with an amount of incredulity by the profession ... I would, however, recommend it in the strongest terms, and in doing so, repeat, it is harmless."*

ALLIMIN, the *safe* hypotensive for long-continued use, is composed of dehydrated garlic concentrate (4.75 gr. per tablet) and dehydrated parsley concentrate (2.37 gr. per tablet). Working smoothly and gradually, through its action as a peripheral vasodilator, ALLIMIN usually provides a very substantial reduction in blood pressure—the beneficial results persisting throughout the period of medication.

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ALLIMIN tablets are enteric coated, tasteless and odorless. The minimal dose is 2 tablets with water, t.i.d., after meals. Intermittent courses of administration, skipping every fourth day, recommended.

*MINCHIN, W. C.: *The germicidal and therapeutic action of garlic.* Practitioner. 100:145, 1918.

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air depots, and other essential industries where workers can be examined in sizable groups.

In less than a year, eight units operated by the tuberculosis control section of the PHS have surveyed seventy-seven war industries in eleven states, X-raying 194,986 individuals. By using 35 mm. film, one unit can expose, process, and interpret 500 films in an eight-hour day. That is twice the number of large films it could handle in the same length of time.

Public Warned

A pamphlet designed to enlist the public in the fight against the medical provisions of the Wagner-Murray-Dingell bill has been distributed by the Wayne County (Mich.) Medical Society. The text, prepared as part of the society's public health education program, includes these passages:

"You, as an American citizen, should oppose the spread of bureaucracy and the resulting loss of your rights and privileges as a free man! As a patient, you should resent the intrusion of politicians into the intimate affairs of your personal life!

"By actual proof we are the healthiest nation in the world. This is because of your doctor's personal attention to your needs as a patient; because you—the patient—have been free to choose somebody else if you thought he could do a better job.

"If the Wagner-Murray-Dingell bill becomes a law, your doctor's success will depend upon political influence. His time will be spent in filling out multitudinous forms of planners and bureaucrats—not worrying about your ills. He won't have time, and it won't make a particle of difference in his income, anyway.

"Do you want six more times than you are now paying deducted from your pay check for 'S.S.' taxes? And an additional sum in the form of increased prices of everything you buy which will result from the added cost of production when employers meet their new portion?

"Don't let anyone tell you it's free!

"Do you want to be a government patient, also just a number, told when and where to get medical care and supplies according to a dictator's blueprint? (Only those drugs listed in the government book can be prescribed.)

"How would you like your baby handled by the OPA?

"Don't let anyone tell you the bill will improve your health!"

Maternity Deaths Down

Maternal mortality in the United States has dropped by more than two-thirds during the last decade, the Metropolitan Life Insurance Company reports. Furthermore, despite the sharply increased birth rate and the shortage of doctors and nurses, provisional reports indicate that the present rate is just below two maternal deaths per 1,000 live births.

as contrasted with a rate of between six and seven prior to 1934.

The improvement has been especially marked since 1936, when no state in the Union had a maternity death rate of less than four per 1,000 live births. By 1941 thirty-eight states and the District of Columbia had rates below that figure.

Syphilis "Scare" Decried

The Rhode Island Medical Journal charges editorially that the menace of syphilis has been exaggerated as a result of a misinterpretation of statistics, and that the incidence of the disease actually is low among white men in the greater part of the nation.

"A national hue and cry has convinced the public of the great prevalence and grave danger of this plague," the editorial says. "The hunt for the *Treponema pallidum* has assumed immense proportions. Not only does every youngster called up to the armed forces have to give his blood, but every nice boy and girl wishing to marry have to 'prove' that they are immaculate in this respect.

"Now it is well worth while that syphilitics shouldn't marry. No more (to reach for ideals) should mental defectives, the tuberculous, or the vast number with various types of nervous troubles. Why not, before the marriage license is issued, demand an I.Q. test, X-ray of the lungs, and a mental hygiene examination?

"The answer, in the opinion of many, is our national tendency to overemphasis. Most of us have wondered why in our practices we have not encountered the syphilitic scourge we have been told about. Smillie . . . has given a good answer. It is largely the old story of the misinterpretation of statistics. Florida, with a large Negro population, has a syphilis rate of 5.3 per cent in white men, 40.6 per cent in

BUSY HANDS MAKE IDLE CLINICS

The sharp decline in the number of outpatient visits to clinics since 1938 is reflected in statistics of thirty representative New Jersey general hospitals, compiled by that state's Department of Institutions and Agencies, and covering years of optimum employment and high wages.

Year	*Outpatient Department Visits*	*Per Cent Change Over Preceding Year*	*Per Cent Drop Since 1938*
1938	805,558	+ 6.1	. . .
1939	799,350	− 0.8	0.8
1940	726,830	− 9.1	9.7
1941	685,010	− 5.8	14.9
1942	545,956	−20.3	32.
1943	433,498*	−20.4	46.2

*Estimated

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That's what Calcreose does, through its provision of Calcium Creosotate. By its local irritative hyperemic action on the respiratory passages, it tends to lessen cough, diminish expectoration, reduce its purulency and deodorize it (in fetor of bronchial secretions). It also helps to improve appetite and nutrition.

Even in large doses, Calcreose is freely tolerated, without gastric irritation or nauseous reaction. Its pleasant odor and taste make creosote administration a readily acceptable and effective therapy.

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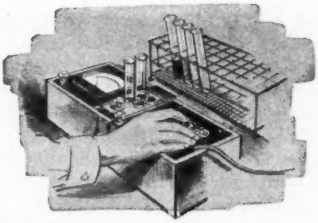

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Calcium Pantothenate 0.5 mg.
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Negroes. Rhode Island, 0.9 per cent white, 9.2 in Negroes.

"Smillie says, 'Data show that most of the popular propaganda that has been used in promoting syphilis control in the U. S. has been highly misleading. "One person in ten will have syphilis," is a popular saying, but it is untrue. The incidence of syphilis among white men in the greater part of the nation is low and is limited for the most part, in the white race, to the lowest classes.' "

Hospital Adds Surcharge

A surcharge of 10 per cent is being added to all bills for services by the Fitkin Memorial Hospital in Asbury Park, N.J., to meet increased operating costs. The surcharge was adopted as preferable to an increase in rates because it can be dropped more easily if costs decline and because it distributes the added expense of operation equally among all classes of paying patients.

Disaster Test

When the Congressional Limited was wrecked outside Philadelphia, the Philadelphia coroner's office had representatives in action at the scene within half an hour. This was the first test of a preparedness-for-disaster program set up by the coroner after the Cocoanut Grove fire in Boston. Bodies were grouped in the morgue by age and sex to facilitate identification, and sixty embalmers prepared them for burial.

Blue Cross Contract

A uniform comprehensive service contract for adoption by Blue Cross plans throughout the United States has been approved by the Hospital Service Plan Commission of the American Hospital Association.

The proposed contract includes the following:

1. An increase in the number of days of protection, based upon continuous membership by a subscriber, namely: twenty-one days the first year, twenty-five the second, and thirty the third year.

2. A substantial discount on hospital bills for an additional time following the full coverage period.

3. Coverage for all services which are available through member hospitals to other than Blue Cross subscribers and their dependents.

4. Emergency room care in accident cases or services required with-

THE SHADOW OF THE YEARS TO BE—

Body pattern moulds of adult life are laid during the critical period of rapid growth.

Faulty nutrition in the child and adolescent may affect physique and resistance to disease in later life.

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Taken between meals, Horlick's does not tend to interfere with the next full meal.

Horlick's is delicious whether prepared with milk *or with water*. The tablets are also useful and convenient to eat at intervals during the day.

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in twenty-four hours after the accident. For all other cases benefits would be limited to the care of regularly admitted bed patients.

5. Coverage for all types of hospital cases, except industrial accidents and diseases, and conditions for which services are provided by a governmental agency. This implies removal of limitations of benefits (within the contract period) for such cases as tuberculosis, mental disease, venereal disease, and self-inflicted injuries.

6. Hospital benefits for family participants, equivalent to those offered to the employed subscriber.

7. Reduction of the waiting period for maternity cases to nine months and removal of all waiting periods for pre-existing conditions for groups of fifty or more employes of which 75 per cent are Blue Cross participants.

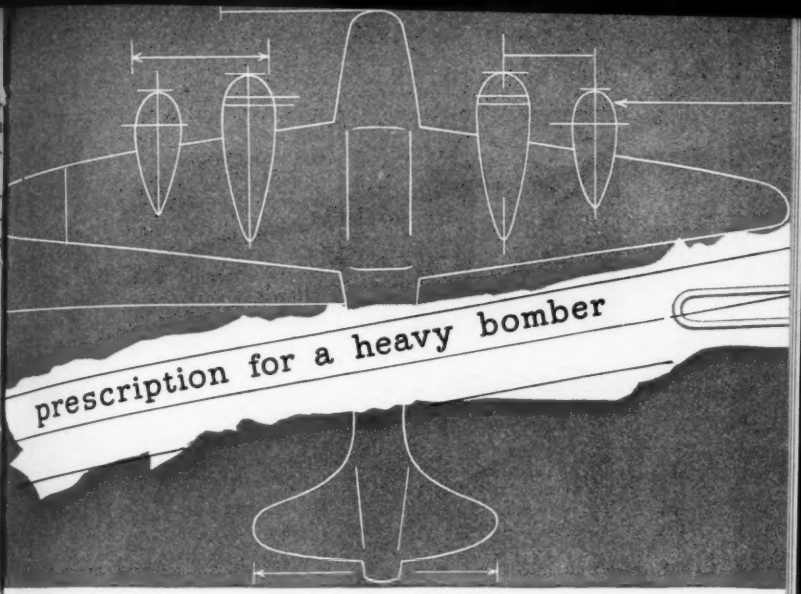
U.S. Aids Foreign Labor

Industrial safety and sanitation for foreign workers employed on U.S. war projects abroad are required under a "labor clause" included in nearly 150 contracts negotiated in the last year with concerns in Latin America and Africa. Additional contracts are pending.

The foreign corporation agrees to provide adequate shelter and water supply, to cooperate in a plan to improve health and sanitation, and to maintain working conditions favoring maximum production. The United States pays half the cost of necessary improvements, the corporation the other half.

Army, Navy Greedy?

Dr. John P. Peters of Yale Medical School, secretary of the left-



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wing Committee of Physicians for the Improvement of Medical Care, Inc., does not believe that the Army and Navy need, or can effectively use, all the physicians they are demanding. Addressing the National Conference of Social Workers, Dr. Peters charged that "the military authorities order physicians as they would material commodities in terms of numbers, the only qualification being age."

"It seems a short-sighted policy, by which the military authorities are sacrificing quality where quality is a prime requisite," Dr. Peters said. "If this war is not ended quickly, they, as well as the civilian population, will feel the lack of highly trained specialists."

The Army and Navy, according to Dr. Peters, are taking medical students who have completed abbreviated courses and hasty internships and assigning them to battalion medical posts where they will be cut off from real medical work for the duration of the war. These men, Dr. Peters declares, are thus deprived of the advanced medical training that makes specialists.

New Weight Formula

A new formula for determining ideal weight, which allows for differences in body build, has been proposed by the University of Illinois. The formula is the same for both sexes and from birth to old age. It is based on height and unexpanded chest girth, measured at the level of the end of the sternum at quiet exhalation.

The unexpanded chest circumference is divided by 4 and the quotient squared; the square is then multiplied by height in inches. (In the detailed formula, this result is

THE Surgeon General's Office of the U. S. Army has asked Johnson & Johnson to aid in its effort to inform the public of the activities of the Army Medical Department.

We hope that through this campaign not only the families of fighting men . . . but Americans everywhere . . . will understand with greater appreciation the courage, skill and devotion of doctors, surgeons, nurses and medical workers at home as well as in the front lines.

Johnson & Johnson

multiplied by the specific gravity of human tissue; but since this is 1, the step may be omitted.) The figure obtained is divided by 27, a mathematical constant, and the result is said to be the ideal weight.

Under the old height-age rating, a man 25 years old and five feet ten inches tall is supposed to weigh about 160 pounds. According to the Illinois formula, he would weigh about 185 if he were stocky, with a chest girth of thirty-four inches, but only about 142 if he were tall and thin with a chest girth of thirty inches.

[Weights of persons with large chests appear excessive when computed by the Illinois formula and contrasted with weights shown on the more commonly use tables.—ED.]

Red Cross Calls Explained

When physicians in Cincinnati complained that the Red Cross sometimes telephoned them in the middle of the night for reports on the condition of certain patients, the local chapter explained that it was a Red Cross function to verify the validity of a service man's request for a furlough because of serious illness at home. The physicians contended that many of the calls could have been made just as well the following morning.

Replied the chapter: "It is only through the physician that adequate information is available. Our staff makes every effort, when at all possible, to postpone calls during the very late hours. If there is indication that the illness is serious, we feel it is in fairness to the service man and his family for a report to be forwarded as quickly as possible, so that arrangements can be made for a leave."

Nazis Seek Dutch Doctors

A German plan to conscript 500 to 1,000 Netherlands physicians for service in Germany has been reported by the Netherlands Information Bureau. Anton Mussert, Nazi leader in Holland, is quoted as having made the following statement on the German-controlled Hilversum radio:

"When one says there is compulsory labor service for Europe, I cannot see why this should not apply to Netherlands doctors. I cannot see why, of several thousand Dutch doctors, there are not 500 to 1,000 in Germany, on a rotating basis.

"I can imagine the Germans saying, 'Even if there are a million Dutchmen coming to work here,

Bacteria Bombardier

Unhesitatingly the military physician faces a menace more deadly than bullets. Epidemics! Dire threat to troops in primitive lands. Epidemiology teams—two officers and four corpsmen—quickly "bomb out" conditions that foster plagues.

Seldom cited, constantly in danger, the military doctor epitomizes America's fighting man of World War II.

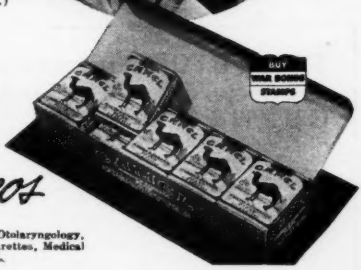
When you send gifts to those in service, send Camel. It's first choice of men in the armed forces*—for welcome mildness, rare good flavor . . . the *thoughtful* remembrance. Send Camels by the carton.

FIRST in the Service

*With men in the Army, Navy, Marine Corps, and Coast Guard, the favorite cigarette is Camel. (Based on actual sales records.)

Camel

Costlier Tobaccos



New reprint available on cigarette research—Archives of Otolaryngology, March, 1943, pp. 404-410. Copies on request. Camel Cigarettes, Medical Relations Division, 1 Pershing Square, New York 17, N. Y.

they will not get German medical care—let them bring their own doctors.' And they would be right. Therefore I assure you I am trying everything possible to get 500 to 1,000 Netherlands doctors to go to Germany."

V-Mail for Hoosiers

Each month some 1,200 Indiana physicians in the armed services, 160 of them overseas, receive a special V-mail letter, often written by a Hoosier celebrity, to keep them in touch with doings at home. The letters are signed "Medsoc" to designate the Indianapolis Medical Society, which sponsors them; but they are actually a product of the energy of Dr. John Ray Newcomb, who conceived, developed, and maintains the wholesale correspondence project.

"I got the idea for Medsoc when the state medical society turned over to me the questionnaires filled out by 112 Marion County doctors who had gone into the service, and asked me to write an article about them for the Indiana State Medical Journal," Dr. Newcomb explained "It struck me forcibly that 80 per cent of the men asked for more letters, and that it would be a nice gesture on the part of the society to mail a monthly letter to every member in the armed services."

He wrote to celebrities he knew, and to some he didn't know, asking for literary contributions. Among those who have responded are Booth Tarkington, Meredith Nicholson, George Ade, Governor Henry F. Schricker, Irvin S. Cobb, Eddie Rickenbacker, Wendell L. Willkie, Cornelia Otis Skinner, and Ernie Pyle.

When a letter is received from a contributor, it is typed and the whole thing, signature and all, is put on a stencil and run off on a duplicating machine. Even the drawings that accompany some of the contributions are included.

Housewives Brew Drugs

Herbs collected from the countryside are being brewed into medicines by housewives in Britain. Digitalis, belladonna, and other drugs are extracted by the women from herbs gathered by county committees under the auspices of the Ministry of Supply.

Orderly Inhales, Dies

A whiff of oxygen was an habitual pick-up for Walter Schlesinger, 32, an orderly in Mount Sinai Hospital in New York. When tired, he'd

NOW THE STUART FORMULA * *either meets or exceeds all recommendations for all vitamins of the Food and Nutrition Committee of the National Research Council, including natural B complex factors and minerals, and is sold at a sensible price that all patients can afford + Compare with any other ethical multivitamin product for* potency, balance and cost.

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go into the anesthesia room for a few invigorating inhalations. Recently another orderly found Schlesinger's body on a stretcher there, an anesthesia mask over his face. The tank with which the mask was connected held, not oxygen, but cyclopropane.

Burden of a G.P.'s Wife

A picture of the wartime burdens of an English practitioner's wife was published recently in the British Medical Journal in the form of a letter from one of those wives, with the editorial note that the letter is typical of many.

"Saddled with a large, old-fashioned house and without maids (a woman for a few hours to help with the rough work in the early morning), I am marooned at home all day," the doctor's wife wrote. "The doorbell rings, on an average, seventy times daily (sometimes more often on market days), and I often have to run downstairs to answer it.

"I do all cooking, bookkeeping, door and telephone answering, helping in the dispensary, washing, ironing, and dusting. I have two children, luckily of school age. Cooking is distinctly difficult; for instance, if pastry is attempted, it usually means doffing apron and washing hands several times to answer the door or phone.

"There are three very busy surgery 'hours' in the house daily and medicine to be handed out in between. Dinner is at 8:30 after the last surgery; then comes the constant drudgery of washing up, laying the breakfast, and blacking out, ending with the booking, which is usually completed about 11:30. There is no leisure; we are never able to go to the cinema. The front

MULFORD COLLOID LABORATORIES
H. K. Mulford
FOUNDER
PHILADELPHIA, U.S.A.

Sulphocol

TRADE MARK REG. U. S. PAT. OFF.

The patient wants relief from pain—the physician must try to prevent further joint damage and deformity.

Colloidal sulfur is a valuable aid in accomplishing both objectives. By its detoxifying action it reduces joint swelling and thus lessens pain, and also prevents or minimizes further joint involvement.

SULPHOCOL offers all the advantages of colloidal sulfur therapy, plus the added factor of non-specific stimulation of antibody formation—two widely used forms of treatment.

Over a period of years SULPHOCOL has been used with satisfactory results in thousands of arthritis patients. The accumulated literature and clinical experience is ample proof of the efficacy and safety of this form of therapy.

SULPHOCOL is available in two forms —SULPHOCOL, in capsules, for oral administration and SULPHOCOL SOL for parenteral use.

We will be glad to send additional information. Write to *National Drug Co.*, Dept. I, Philadelphia 44, Pa.

National Drug Company

PHARMACEUTICALS, BIOLOGICALS, BIOCHEMICALS FOR THE MEDICAL PROFESSION

doorbell is being extended to sound in the garden to enable me to weed and cut the lawn in odd moments.

"Before the war we had three maids, a charwoman, and a dispenser-receptionist; now the practice is far larger and we have no maids or dispenser. When illness creeps into the home or we have to do spring cleaning or send out the quarterly bills—all these I leave to the imagination!"

Food Canned for Hospital

An assurance of winter food supplies, as well as a 25 per cent cut in food costs, has been provided for the Salem Hospital, Salem, Mass., by a food conservation project manned by volunteers from twenty-four churches. The contribution of 9,500 hours of work up to July 15 achieved these results: 100 cases of asparagus produced 1,608 quart cans, 900 quart boxes of strawberries were converted into 453 quarts of preserve, and 114 bushels of green beans made 2,700 quarts.

The hospital also rented a root house for storage of sixty tons of potatoes, three tons of squash, 250 bushels of carrots, 125 bushels of cabbage, and twenty-five bushels each of beets and parsnips.

The program was conceived after the OPA had ruled that the hospital could expect only 50 per cent of the processed foods consumed last year.

Feeding Problem Solved

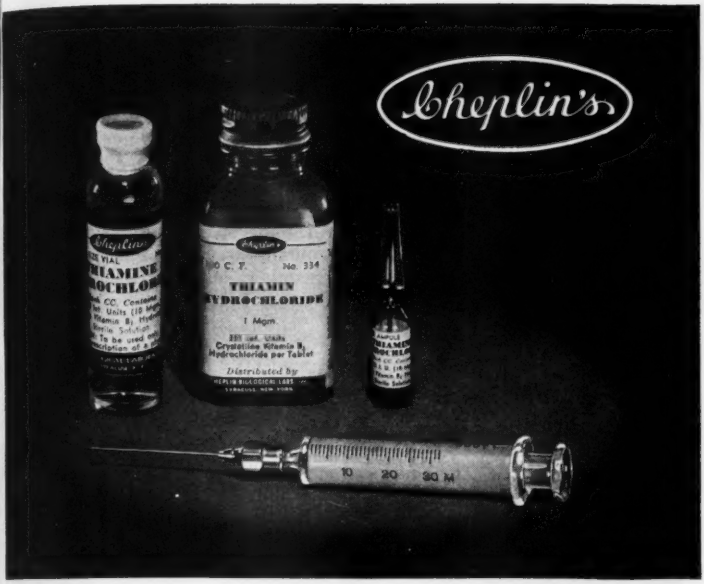
"Dr. J. P. Caldwell answered another night call—and helped to pull a Northern Pacific limited through," The Associated Press reports from Cheney, Wash. "The train reached Cheney with an iron bar stuck in its automatic stoker, so an extra fireman was needed. Station Agent Robert Horne spotted Dr. Caldwell in the depot. The physician fed the firebox for 130 miles, from Cheney to Pasco."

Maternity Wards Deserted

Despite a sharp increase in the birth rate, New York City's Commissioner of Hospitals Edward M. Bernecker reported recently that only 390 of the 708 city-hospital beds reserved for maternity cases were occupied. More women, he says, are patronizing private hospitals now that incomes are higher.

Jailbirds Serve Hospitals

New York City's experimental employment of workhouse prisoners in city hospitals, to help ease the



Thiamine Hydrochloride

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THIAMINE HYDROCHLORIDE for intramuscular & intravenous use:

6.66 mg. in 1 cc. ampules

10 mg.
25 mg.
50 mg.
} **per cc. in 30 cc., 60 cc., and 100 cc. vials**

60 mg. per cc. in 1 cc. ampules, 10 cc. and 30 cc. vials

Oral Use:

1 mg.
3.1 mg.
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} **tablets in bottles of 50, 100, 500 & 1000**

(1 mg. of thiamine hydrochloride is equivalent to 333 Int. Units.)

Literature on request.

"ACCEPTED STANDARDS AT AN ACCEPTABLE COST"

CHEPLIN BIOLOGICAL LABORATORIES, INC.
(Division of Bristol-Myers)
Syracuse, New York

manpower shortage, has been defended by Mayor F. H. LaGuardia, following bitter criticism of the practice by a Kings County judge who twice ordered it investigated by a grand jury. The judge charged that twenty prisoners were employed at a Staten Island, N.Y., hospital and that among them one had a record of fourteen convictions, two were moral perverts, one was a purse snatcher, and one had been convicted of carrying burglar's tools.

The Mayor replied that prisoners did not come in contact with patients. "It's purely experimental and I don't know how it's going to work out. We try to sweat some of the sin out of them."

LaGuardia did not disclose how many prisoners were engaged in such work.

Prepayment in N.H.

The New Hampshire Medical Society has approved a plan for prepaid medical and surgical service for residents of that state, to be provided by an organization known as the Blue Shield and administered by the New Hampshire Blue Cross. Its announcement emphasized that rural residents would be included in the plan and the premiums would be low enough to appeal to citizens in the lower and middle income ranges, as well as the higher brackets.

NPC's Gallup Poll

The National Physicians' Committee estimated last month that the country-wide survey being made for it by the Opinion Research Corporation (subsidiary of Dr. George Gallup's American Institute of Public Opinion) will be completed on or about February 1, 1944. The public

is being asked to express its point of view on (1) the status of physicians in the community, (2) the adequacy of medical care, (3) medical service plans, and (4) compulsory health insurance.

Techniques similar to those of the Gallup polls are being employed. Says NPC: "Attitudes will be determined and facts will be established on which to base plans for insuring adequate medical service and methods to be employed in the all-out effort to preserve the framework of private medical practice in the United States."

A preliminary test survey completed by the Gallup organization in October revealed:

That 90 per cent of the persons interviewed respect and are favorably inclined toward their physicians;

That 75 per cent had never heard of federal medicine; but of the 25 per cent who had heard of it, half favored it;

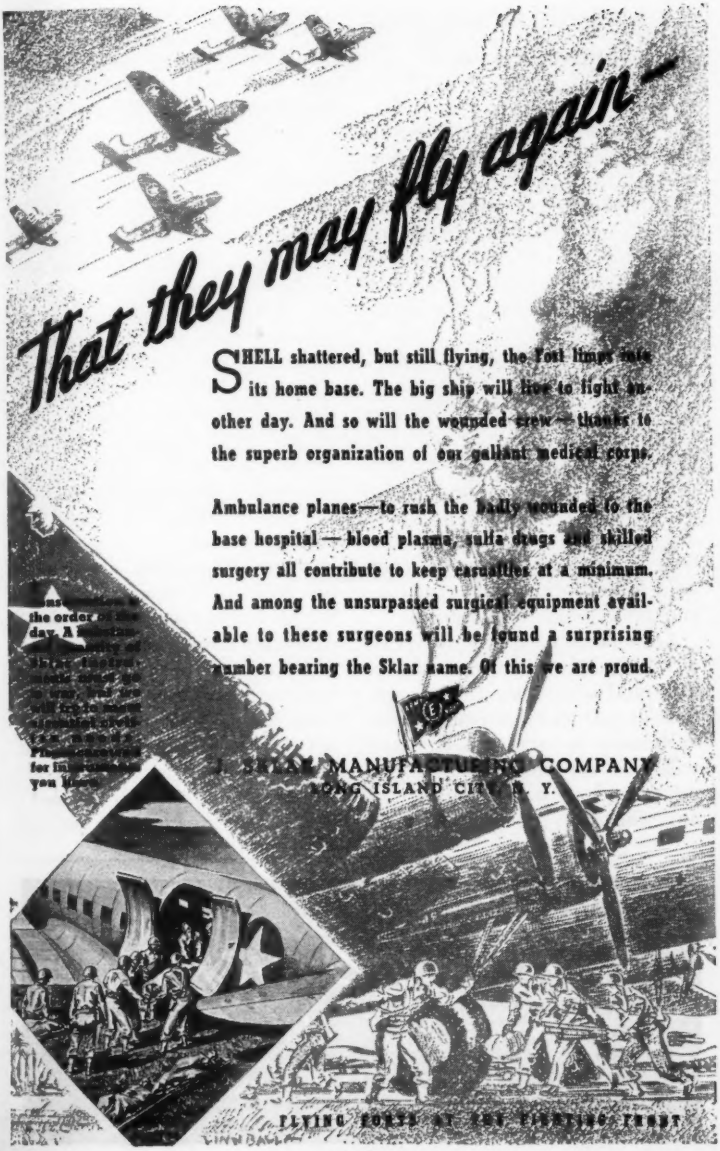
That most persons receptive to federal medicine were anxious for protection against the expense of catastrophic illness.

These preliminary findings are, of course, not conclusive.

Fewer Fatal Accidents

Fatal accidents were 7 per cent fewer in the first six months of 1943 than in the same period of 1942, says the National Safety Council, despite the fact that man-hours of labor in the nation increased 17 per cent in the same period. Traffic deaths were down 41 per cent, largely because of wartime traffic restrictions.

Pictures in This Issue
Page 54, OWI photo; 60, Philadelphia Record.


That they may fly again—
SHELL shattered, but still flying, the Fort limps into its home base. The big ship will live to fight another day. And so will the wounded crew — thanks to the superb organization of our gallant medical corps.
Ambulance planes—to rush the badly wounded to the base hospital — blood plasma, sulfa drugs and skilled surgery all contribute to keep casualties at a minimum. And among the unsurpassed surgical equipment available to these surgeons will be found a surprising number bearing the Sklar name. Of this we are proud.
J. SKLAR MANUFACTURING COMPANY
LONG ISLAND CITY, N. Y.
FLYING FORTS AT THE FIGHTING FRONT

U.S. Medical Teams

[*Continued from page* 56]

purification plants and delousing stations. The standard unit is designed to supply the needs of 1,000,000 people for three months. There are also "supplemental packages" which contain special medical supplies to combat epidemics or diseases peculiar to certain regions.

Hospital and laboratory equipment is being put up in the same way. One type of hospital unit contains all the equipment necessary for a fifty-bed hospital; the other will equip a 150-bed set-up.

Separate units of equipment are prepared for epidemic-control laboratories, for emergency field laboratories, and for a central pathological laboratory.

Dr. Crabtree expects the OFRRO to find three problems in reoccupied areas: starvation, epidemics, maternity and infant care.

Broadly speaking, each team will give administrative and advisory aid to native physicians and officials in the following program: (1) the restocking of hospitals, drug stores, and other arsenals of medical supplies; (2) establishment of delousing stations; (3) control of venereal disease; (4) establishment of public health departments where necessary; and (5) establishment of centers where mutilated persons can get artificial legs, arms, etc.

Dr. Crabtree believes his teams face a tough job. Last month he remarked gloomily that "Ominous news has come of typhus fever in the Balkans. In the Mediterranean countries alone, cases of malignant malaria are numbered in millions. The enteric diseases, particularly typhoid fever and bacillary dysentery, are on the increase in every occupied territory. The dark shadow of tuberculosis becomes increasingly heavy over every country about which we have trustworthy information. In all occupied areas infant mortality rates have increased from 20 per cent to more than 60 per cent above pre-war levels. Premature births and miscarriages have more than doubled."

—CHARLES WINTERS

Designed for the patient's PROTECTION

THE "RAMSES"* Prescription Packet No. 501 supplies the patient with:

1. A "RAMSES" Flexible Cushioned Diaphragm of the prescribed size.
2. A "RAMSES" Diaphragm Introducer of corresponding size.
3. A large size tube of "RAMSES" Vaginal Jelly.

This complete unit is available on your order or prescription through all recognized pharmacies.

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Federal Maternity Program

[*Continued from page* 53]

ciety says. "Now the third helping is needed in some states. The main idea apparently is to keep everyone running back with their empty buckets for a refill at the fount in Washington."

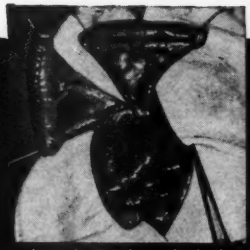
That observation, in the light of statistics, is a cogent one. Secretary of Labor Frances Perkins estimates that the new $18,600,000 appropriation will provide care for an additional 220,000 wives and babies up to July 1, 1944. But it is estimated that at least 645,000 babies will be born to wives of enlisted men in the same period. Since each birth will cost the government approximately $85, including hospitalization, almost $55,000,000 would be required if every mother decided to take advantage of the program. Granted that many may not, it still seems likely that the Children's Bureau will have to see Congress about more money before the end of the fiscal year.

At this writing forty-four states, the District of Columbia, Alaska, and Hawaii are participating. Between April 8, 1943, when the first state, North Carolina, put its plan into operation, and September 1, about 70,000 cases had been approved throughout the country. Federal officials expect that 20,000 to 25,000 applications a month will be made during the remainder of the fiscal year.

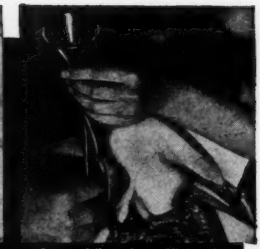
—CLARENCE FISHER

Sal Hepatica's LIQUID BULK

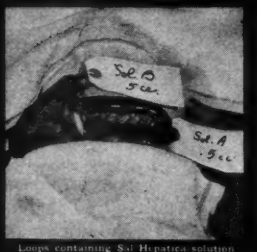
1. Helps stimulate peristaltic muscles.
2. Aids in maintenance of proper alimentary water balance.
3. Assists in the neutralization of excessive gastric acidity.
4. Is useful in promoting bile flow.



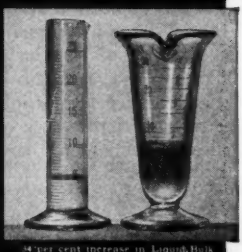
Loops of a dog's ileum isolated and ready for LIQUID BULK experiment



Loops of ileum being filled with laxative solution of Sal Hepatica



Loops containing Sal Hepatica solution replaced in peritoneal cavity for one hour *



34 per cent increase in Liquid Bulk of Solution A after one hour.

BIOLOGICAL TESTS SHOW HOW SAL HEPATICA INCREASES LIQUID BULK

Because modern medical men recommend gentle yet thorough relief for constipated patients, Sal Hepatica has achieved an enviable position among saline compounds for its ability to create nonabsorbable *Liquid Bulk* in the costive bowel.

Recent biological tests have conclusively corroborated the production of *Liquid Bulk* in the bowel by Sal Hepatica. *5 cc. of Sal Hepatica (laxative solution) increased 34 per cent in *liquid volume* in an isolated loop of a dog's proximal ileum, in one hour.

Bristol-Myers Company, 19-11 West 50th St., New York

★ ★ ★

SAL HEPATICA

supplies Liquid Bulk to help Flush the Intestinal Tract

Speaking Frankly

[*Continued from page 22*]

the senior year. Only in this way can system and efficiency be ingrained in the doctor. Later when habits have been formed, the job is almost impossible.

Most physicians' offices contain a fair cross-section of ancient, medieval, and modern medical literature. There is no index. Memory is shadowed. The needed article cannot be found. Time is lost searching.

Because of this lack of system, most physicians' libraries aren't worth ten per cent of their cost. Your card index and vertical filing of tear sheets seems flexible and just about conclusive.

C. J. Estes, M.D.
Harrisburg, Ill.

Phone-Advice Fees

Re the article in September MEDICAL ECONOMICS entitled, "Do You Use the Phone to Cut Your Volume of Calls?":

Diagnosis and treatment by telephone should be regarded purely as a stopgap until the doctor arrives. It should be understood between the patient and the physician that this type of treatment is inadequate and that there will be no charge for it.

Sidney Anderson, M.D.
Alamosa, Col.

Though I haven't started charging for advice given by telephone, I heartily agree that it should be done in certain cases.

Walter Weissenborn, M.D.
Hartford, Conn.

After reading your recent article on telephone "consultations" I should like to make this observation:

My field is pediatrics, so I necessarily receive a great many phone calls and give a good deal of advice over the wire. But the patients are well, and they need only a change of formula, etc. When a patient is ill, no diagnosing or treatment should be attempted over the phone.

L. Minor, M.D.
Middletown, Conn.

Over the phone a patient may tell his physician he has a little indigestion. On actual examination it may prove to be a ruptured appendix.

M.D., California

If my patients would limit their phone calls to requests for information about minor ailments, all right.

But they phone for advice on everything from dogbites to skin rashes to vomiting.

My policy: Give advice only in trivial cases.

In non-trivial cases I tell the patient I cannot take the responsibility for advising over the phone inasmuch as anything I might suggest would necessarily be based on guesswork.

Max Weikersheimer, M.D.
Boulder, Col.

It used to be my policy after visiting a patient to make a second call the next day. Now, however, I ask patients to telephone me the next day, instead. If they're better, I do not make a second call.

This cuts in on my income but it also gives me a rest occasionally and allows more time for really sick patients.

F. E. Carmichael, M.D.
Portland, Me.

. . . I think telephone conversations which convey valuable professional advice should be paid for . . .

Harold A. Pingree, M.D.
Portland, Me.

I do not believe in absent treatment. If the doctor does not have time to take a case, let him say so. There is no doctor shortage as long as prejudice is rampant in the profession and doctors raise hell because some patients go to osteopaths.

G. C. Wilke, M.D.
Fort Collins, Col.

It is a great aid at times to ask patients to report their condition by phone. It is a simple matter in such cases to fail to prescribe if you feel the patient is taking advantage of you or is really in need of a visit.

I think half the usual fee is sensible for these calls, though it has never been the custom to charge them in this district.

Beryl Moore, M.D.
Oxford, Me.

If a doctor renders service over the phone in the manner described on page 119 of your September issue, he should charge a fee. Half the usual fee, I think, is fair.

W. O. LaMotte, M.D.
Wilmington, Del.

I have been able to collect for phone advice only in rare instances. Such advice belongs in the same category as the "curbstone consultation."

M.D., Maine